Religion, Culture, and Mental Health

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with an Introduction by Talcott Parsons

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Third Academy Symposium

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Introduction

by Talcott Parsons

The third symposium of the Academy of Religion and Mental Health, held at Arden House on November 6–8, 1959, the proceedings of which are presented herein, was a notable event to those who, like myself, had not previously participated in the work of the Academy. Not least among the reasons for this were the composition of the group and the serious but very free and relaxed character of the discussion. It seems to me that such a meeting would have been very much more difficult, if not impossible, as recently as ten or fifteen years ago.

This, of course, is not the first time that clergymen and laymen interested in problems of religion have sat down together for serious discussion. In the field of mental health, psychiatrists, psychologists of the academic persuasion, sociologists, and anthropologists have built up a relatively well developed pattern of mutual communication within the last generation. On the lay side, all four groups were well represented. There has also been a growing interest in the psychology and sociology of religion, both among the clergy and among the behavioral scientists, and persons professionally concerned with this interest were unusually well represented. Finally, interdenominational discussions have become increasingly frequent in recent years, among both clergy and laity. This appeared to me an especially notable gathering partly because of the unusual amount of participation of representatives of the three major faiths and partly because of the frankness of discussion across denominational lines.

As in many other connections, fruitful discussion is possible only if there is mutual respect for the deep personal commitments that have been undertaken by the various participants. This inevitably imposes certain limitations on the problems that can be

opinion, one of the most striking and significant facts of the last generation in social science is the rapidly waning strength of the positivism of the nineteenth century This is not to say that positivism is by any means dead, but certainly it has ceased to be dominant in the older sense

Perhaps the most important scientific development underlying this change is the very great weakening of the idea of reductionism, the conception that true scientific explanation of complex phenomena always consists in reducing them to more elementary terms Thus the "ultimate" explanations of chemical phenomena were held to be physical, biological phenomena were reduced to chemical or physical, and of course cultural, social, or psychological phenomena were reduced to biological or even physical terms Since religion clearly belonged in the "higher" areas of the latter fields, if it was to be scientifically studied at all, it seemed to follow that the "ultimate" scientific explanations of religious phenomena would have to be found in instincts, or in the metabolic needs of organisms, or in the biochemical constitution of these processes

Reductionism in this sense has been replaced by a conception of differentiated and interpenetrating levels of organization, with no presumption that any particular level has ontological priority over any other, though there may be temporal priority in an evolutionary sense and hierarchical priority in a sense of cybernetic control The way for this change of perspective was prepared by philosophers of science such as Whitehead It has been made respectable in the "hardest" of hard sciences by the emergence of cybernetics and information theory in physics and engineering It has become particularly salient in the analysis of the neurophysiological mechanisms of complex behavior in such a way as to promise a genuine articulation between physiology and the behavioral sciences in general, an articulation that does not simply sacrifice the latter as independent bases of explanation to the former

Seen from this point of view, the "higher" functions of the human personality, the organization of societies, and the historic content of cultures can be treated as objects of scientific investigation in their own right, which need not be interpreted to be simply "manifestations" of a more ultimate reality at a lower level of organization This means that the very substantial information that has

dividual in a sufficiently differentiated culture, his beliefs about the empirical world cannot be deduced simply from his beliefs about the grounds of meaning, and it is patently irrational to hold that the gap between them has been filled by detailed revelation that makes science itself a meaningless enterprise If this is true of the physical world, it must also be true of any part of the world of reality that is intrinsically subject to empirical investigation

This assertion of the element of mutual independence of religion and science, including behavioral science applied to religion itself, does not, however, imply the absence of interdependence On the contrary, the religions of the Western world are part, and in a fundamental sense the most *important* part, of the *same* basic cultural tradition that has produced modern science The fusion of Christianity with Greek rational thought is the historical foundation of this interrelation Seen in its broadest comparative framework, the "warfare" between science and religion in the modern Western world is altogether incidental compared to their deeper lying affinity The central common commitment is to the maximization of intelligible meaningfulness to the world of experience, including definition of those limits of rational understanding that are an essential part of any sophisticated religion

The attainment of higher levels of generalized rationality in the empirical sciences must thus be conceived as part of a larger cultural tradition in which other elements are also more rationalized, in particular, rational theology with its articulation with technical philosophy plays a central part To our present concern, one vital consequence is that in both respects the range of mutual understandability, so far as the intellectual components are concerned, is widened This applies to both of the major components with which we are concerned [1]

From the *scientific* point of view, this range of rational under-

[1] *In analyzing a cultural system (in my capacity* as a behavioral scientist) I distinguish four major classes of components Besides the patterning of the grounds of meaning and of empirical cognition *referred to above,* I would also include patterning of value-commitments and of expressive symbolization in the appreciation of objects of '*cathexis*' *Cf Theories of Society* Parsons, Shils, Naegele and Pitts, Eds, Introduction to Part IV, Glencoe, *Ill*, Free Press, *1961*

standing clearly must include some understanding of the nature of the religious commitments held in the different religious groups, of the meanings given to the transcendental as well as the empirical objects of their orientation, and of the ways in which these meanings are articulated with the various other aspects of their life-situations with respect to the personality of the individual. The fact that such a range of rational understandability is both essential to science and positively attainable is not incompatible with the assumption that there is an ultimate residuum of religious experience that is not reducible to such terms, some of which may not be accessible to the person who does not share the particular religious commitment. To say, however, that there are limits to the scope of scientific understanding is by no means to say that what lies beyond these limits is the primary determinant of the relevant phenomena, so that the results gained by scientific method are useless or misleading. Furthermore, there is every reason to believe that these limits are historically variable and relative, especially so because, with the progress of science and the development of the rest of the cultural tradition of which it is a part, the range of the rationally understandable can be substantially extended.

pression of mere deviation and to think that it will one day be brought "under control"

It thus seems reasonable to interpret the problem of the behavioral scientist's relation to religious commitment in the light of the general process of differentiation in the culture and in the social structure of roles that is going on in our time. As I have noted, the emergence of the sociology and psychology of religion is itself a profound symptom of cultural change, one aspect of which is the development of a capacity for independently objective study even of the phenomena that underlie the most ultimate commitments of the student himself. In this respect, the problem raised by Professor Kolb is an important part of the larger one of the emergence of behavioral science to an approaching maturity. On the one hand, this makes possible a scientific orientation that is not *inherently inimical to religion, though of course it is incompatible* with various types of religion, such as the belief that the entire Bible is divinely inspired. On the other hand, it makes possible a further extension of the "rationalization" of religion itself, a most important manifestation of which is an extension of tolerance in the sense that rational discussion between religiously differing people becomes facilitated. Such discussion clearly cannot be fruitful without the existence of a common cultural framework in terms of which mutual understanding can, up to a considerable point, be achieved.

This is perhaps the best point at which to introduce the question of the significance of the concern with mental health in its relation to religion. In the first place, somewhat parallel to the emergence of the behavioral sciences relative to their older physical and biological sister sciences has been the differentiation of the field of psychological medicine from the somatic medicine that earlier in this century virtually monopolized the field of "scientific" medicine. The scientific base of psychological medicine is far from being fully secure, but it has broadened out greatly from the beginnings, of which the contributions of Freud were the most important, to begin to incorporate systematically the relevant parts of academic psychology, sociology, and anthropology as these disciplines have been evolving. Moreover, as noted above, developments in the understanding of the operation of the central nervous system have begun

to make the old body-mind dualism increasingly obsolete and irrelevant.

Turning now to the substantive side, comparative and historical knowledge, especially perhaps through anthropological research, have greatly deepened our understanding of the intimate connections between religion and health and have virtually eliminated the earlier positivistic tendency to scoff at the claims of the importance of magical and religious healing. Obviously much of this change arises from research within the field of psychological medicine.

Indeed, what has been happening is the bringing of an increasing range of the disturbances of the human personality under scientific study and within the reach of therapeutic procedures based on scientific knowledge. This, like the other processes that have been discussed, is to be regarded as a process of differentiation. Religio-magical curing is clearly the matrix from which this process of differentiation has taken place. In many primitive societies, indeed, there has been a tendency virtually to deny the occurrence of what we mean by physical illness in other than a symptomatic sense. The first big stage of the differentiation, then, has been the full establishment of the autonomy of the body from this point of view, the recognition that it can become ill for reasons that have nothing to do with motivation, social participation, or spiritual state. Clearly this process got its first big impetus from the Hippocratic tradition in Greece, but it has had an enormous development in our own time.

Against this background, then, there has occurred the differentiation of psychological from somatic medicine, with the scientific character of the former being taken for granted as an ideal. Since every process of differentiation requires new patterns of integration, it was to be expected that a field such as that of psychosomatic medicine should grow up to deal with the subtle connections between the differentiated components. The important point to note is that, for such interstitial disciplines to find a secure place, it is necessary that the two between which they function interstitially must have secured the order of independence from each other that goes with genuine differentiation.

Considering the historic background, however, until very recently a comparable consideration of the interstitial bridge between re-

ligion and health generally, mental health in particular, has not been available. It seems to me that the great importance of the work of the Academy should be understood in the light of this situation.

The broad independence of science from religious commitments discussed above has, with a few exceptions, for a considerable time been taken for granted for somatic medicine. Thus it is not thought that the qualifications of a physician to care for cases of infectious disease or surgical conditions has any special relevance either to his own religious faith or to that of the patient. In the case of mental illness, however, this is by no means to be taken for granted. It was, therefore, in my opinion important evidence of the process of differentiation that has been taking place that, in relation to the question of whether or not it is essential that a mental patient be treated by a psychiatrist of his own faith—a question raised by Dr. Harvey J. Tompkins, and especially elaborated by Father William C. Bier, S.J.—the general consensus of the conference was that it is not essential, though certain subtle problems certainly remain.

For purposes of this brief introduction, it has been possible to deal with only two issues: the problem of the nature of the independence, yet also interdependence, of religious commitment and scientific orientation; and on the other hand, the problem of the differentiation between the problem of health—in particular mental health—and the state of the individual in relation to his religious faith. Both of these problems belong in the context of the differentiation that is going on within Western culture and society generally—indeed, beyond that, on a world-wide basis. However, since differentiation without integration is certain to lead to conflict and disorder, the problem of integration is a very urgent one. The Academy seems to me to be a very important agency in working out such integration at some very critical points in the situation of modern culture.

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Religion, Culture, and Mental Health

A Sociological Approach

Discussion Leader:
TALCOTT PARSONS, PH D

Discussants:
DAVID L. SILLS, PH D
SAMUEL Z KLAUSNER, ED D

A Sociological Approach

Opening Remarks by Dr. Parsons

The sociologist approaches the subject of religion and mental health from a position somewhere in the middle He is not an expert in mental health, nor a proponent of a religious doctrine, he is probably not even a lay student of religion, unless be has specialized in the sociology of religion He is not a practitioner, as the psychiatrist and the clergyman are, the one with responsibility for the mental health of the individual and the other charged with ministry to the spiritual life of his parishioners His professional task is to study scientifically human action and social relationships From his special vantage point, therefore, be views in different perspective the two problem areas of religion and mental health, both of which impinge upon the problems of society in a curious combination of similar and different ways The effort to disentangle these similarities and differences offers a challenge to the professional sociologist

Our whole system of values heavily emphasizes achievement of the social unit, which leads us back to the individual as a unit Though we accept the theme of equality of access to opportunity for achievement, we do not necessarily believe that the loser of the race, however courageous, should win as many honors as the victor We believe in rewarding excellence We do not think it fair if the person who did not achieve certain levels of performance was held back through reasons beyond his control, if they were reasons that can be controlled at a human level, such as elements of health, education, and other components of opportunity Society feels great concern to see that every person has every opportunity that may be afforded him Underlying achievement is quite clearly the

capacity for achievement; aside from biological heredity, capacity can be broken down into the two fundamental components of health and education.

The mental health problem, or mental illness as a disturbance of capacity, has recently emerged into salience in our society. Why this should be so, and the extent to which it is so, are matters we only partially understand. Our growing knowledge of mental health and illness is partly accountable; many things not previously considered in that category are now seen as belonging to it. Another factor is increasing control of somatic illness with more prominence given to the mental-behavioral area in the total field of health. And subtler changes of the social definition of these things make us more ready to look at problems of individual disturbance and incapacity in a new light.

Mental health problems, it seems to me, have their roots most particularly in those components of the personality structure that are related to the individual's early social experiences, notably in interaction with his parents and other members of his family. For these insights we are chiefly indebted to Freud. From the societal point of view, there is an important connection between the motivational foundations of the personality, the family as a social institution and the things that are wrong in the way in which families handle their children (which are to some degree the consequences of the early childhood experiences of the parents), and a whole complex of concerns with what can be done about disturbances from outside the family setting, particularly by the psychiatric branch of the medical profession. Points to be considered here are, first, the equipment of the medical profession to serve in this area and, second, the relation of the profession to other groups with claims in the field, such as the current active competition between psychiatrists and psychologists.

Now, just for a moment, let me turn to the religious side of the question. I feel that, although problems of religious orientation and commitment are matters of individual decision, there is an important asymmetry here. Institutional, organized religion has not been oriented to the problems of the individual in the same sense that the medical profession always has been. This has to do with the

fact that the points at which religion has become institutionalized in its relations to society appear on the macroscopic levels of society To put it crudely but sharply, the problems of church and state take precedence in the history of religion over the problems of the cure of souls The psychiatric profession has no comparable problem of mental health and state, it is much more individual-oriented This is not to suggest that the spiritual problems of the individual are not important in the concern of the church, the history of the church shows the contrary But the setting and the sociological reference of the concern are different

Although there has been historically a close relationship among these areas, I think it is broadly true that the more primitive the society, the more intimately related and the more regulated by processes that are extremely difficult to disentangle from one another have been three problem areas the religious state of individuals, the integration of social groups other than those specialized around religious interests as such, and the health, particularly the mental health, of individuals

Spiritual healing of one or another sort has been prominent from the earliest times, it certainly had an important emphasis in early Christianity What aspects of it could be called psychiatric, what related to facets of internal medicine, what was religious in an analytical sense cannot easily be worked out But as the scientifically-based professions have developed and proliferated in modern society, a range of problems has become fenced off, though with indeterminate border lines at some points, as the province of applied science I doubt that many in this group would agree that religion in the traditional Judaeo Christian sense is science, or that the two should not be differentiated Only Christian Scientists maintain this belief, though there are signs of change going on

This raises the problem of the relevance between these two fundamental aspects of the human situation in themselves, in their relations to each other independent of societies and through societies I think the family health—particularly the mental health—complex and the religious complex are border areas of society, areas in which deeply important human concerns are organized They are partly societal and partly nonsocietal, but they could

never be, in a simple sense, redoced to societal. To attempt so to reduce them seems to me the fallacy of the more naïve functional interpretations of both religioo and mental bealth. I would like to emphasize the "both," because both are important to the functioning and stability of societies. Not only do the people who are concerned with both fields inevitably come up against the social aspects of their problems, but the ways in whicb both impinge upon the society, and the combination of similarities and differences, may be instructive as an approach to understanding the functions of these different aspects of buman orientation for the human situation more generally.

Current Research in Sociology of Religion and Mental Health

Dr. Sills, asked by Chairman Klineberg to supplement Dr. Parsoos' opening statemeot with an account of some of the empirical research being done on the sociological aspects of religion and meotal health, turned his attention to the frustrations that face a social researcher io this field and the available resources and opportunities.

Since the time of Durkheim, sociologists have been saying that religioo serves society as an integrating force; that it performs various functions for society; that it contributes to the mental health of the society because it keeps the society from being disorganized. This is the simplest form of the sociologist's view of the relation between religion and mental health. It seems to be borne out by observation, though it is difficult to produce experimental or quasi-experimental data to prove it.

Io fact, research so far has uncovered little positive evidence of a relationship between the holding of religious beliefs or attending religious services and mental health. In the 1920's and 30's, Hartshorne and May conducted a series of studies of the moral behavior

of individuals,[1] they found there was no difference in such behavior related to whether or not the people had received religious training held religious beliefs, or participated in religious ritual Herman Lantz studied 1,000 students at Ohio State University, finding no correlations between religious activities and personal satisfactions with social conditions [2] Austin Porterfield studied a large number of American communities without finding any correlation between indices of social well being and religious activity as measured by church membership per 100,000 population and the number of ministers in the communities [3] Philip Smith found no significant correlation between the strength of organized religion in a com munity and that community's crime rate [4] These are examples of the paucity of empirical, statistical evidence to support the hy pothesis that religion does serve an integrating function in society nnd that it does relate somehow to the mental health of the mem bers of n society Dr Sills noted that this lack of data does not prove that religion and mental health are or are not related, he wanted merely to point out that the metbodology and opportunities for research so far available have not proved anything definitive The research done has been exploratory, it has been based on small samples, nnd many of the people doing it have been somewhat un sophisticated from the point of view of theory or methodology

Research by sociologists into the relation between religion and mental healtb is certain to increase in the next few years Dr Sills prophesied, not because there is any noticeable revival of interest in religion among sociologists but rather because the number of

[1] See Hugh Hartshorne and Mark A May *Studies in Deceit* Hugh Hart shorne Mark A May and Julius B Maller *Studies in Service and Self Control* and Hugh Hartshorne Mark A May and F K Shuttleworth *Studies in the Organization of Character* Teachers College Columbia Uni versity in collaboration with the Institute for Social and Rel gious Research New York The Macmillan Company 1928–30

[2] Lantz Herman Religious Participation and Social Orientation of 1000 University Students *Sociology and Social Research* 1948–49 *33* 285–90

[3] Porterfield Austin L "The Church and Social Well Being A Statist cal Analysis *Sociology and Social Research* 1946–47 *31* 213–19

[4] Smith Philip M Organized Religion and Criminal Behavior" *Soci ology and Social Research* 1948–49 *33* 363–67

sociologists is increasing so rapidly and the amount of money being spent on social research of all kinds is growing so fast that there are sure to be more researchers interested in the snbject and more funds available for their work. New journals are being published; the *Review of Religious Research* published its first issue this past summer. Foundations, including the National Science Foundation, hitherto cool to the social sciences, are sbowing more interest. Much of the researcb that is sure to be done on religion and mental health in the next decade will be done by persons specially trained for it; theological seminaries today are both training people for this kind of research and occasionally sponsoring it.

University-affiliated social research agencies in the United States are already establisbed and functioning, said Dr. Sills. For example, there is the new Survey Researcb Center at the University of California in Berkeley under the direction of Charles Y. Glock, whose chief personal research interest is in the sociology of religion. Dr. Sills predicted that a great deal of researcb in the sociological aspects of religion and mental health will be done there in the next five years. The Institute for Social Research at the University of Michigan has a large number of researcb personnel interested in group dynamics, and may well turn some of its attention to the area of religion and mental health. The National Opinion Research Center at the University of Chicago has a major commitment to health research. At Columbia University, the Burean of Applied Social Research, with which Dr. Sills and Dr. Klausner are affiliated, currently has three projects in religion and mental health and four others in the sociology of religion out of a total of some twenty-eight projects.

With all the resources availahle for sociological research, bowever, much still needs to be done to procure funds for investigation in the field of religion and mental health. Government agencies and foundations alike are reluctant to support research into projects bearing the label "religion," although both groups have done so. Dr. Sills believed that the Academy should be an important stimnlus in this direction, becanse its activities are giving a scientific tone, not a purely religious one, to the work in this field, a fact that impresses both foundations and government agencies. In the next

decade, Dr Sills thought, trained and interested personnel for research are likely to be more plentiful than valuable ideas for research He said that if this conference produced even one first rate idea for a field project, it would have been a successful weekend

Nature of Religious Experience Important in Research

Chairman Klineberg remarked that Dr Sills's report seemed to reinforce something that had been brought out in the 1958 Arden House conference under Dr Allport's leadership Because the statistical relation between religious behavior and mental health or prejudice does not indicate very much, Dr Allport had suggested that the whole research area should be broken down on the basis of what religion means to the individual, Dr Klineberg recalled The important distinction Dr Allport had made between a kind of intrinsic or "true" religious attitude and an extrinsic one, the latter being a more or less external behavioral phenomenon, was one way of attacking the problem The kind of research Dr Sills had been talking about raised the same problem Lumping together all forms of religious association or identification resulted in mixing up very different kinds of behavior Instead of looking for statistical correlations between religious behavior and mental health, researchers should look more carefully at the nature of religious experience

Dr Allport added support for this view from a new book entitled *Religious Behavior*,[5] in which the author, Michael Argyle, makes the error of looking for correlates of anything called religion It is an elementary mistake to assume that everything bearing the semantic label of "religion" can be dealt with as one phenomenon One must get inside the personality and find out what religion really means to the person before he can make any intelligible corollary

5 Argyle, Michael, *Religious Behavior* Chicago The Free Press 1959

Studies by the Bureau of Applied Social Research

Dr. Klausner described a series of research projects in the field of religion and mental health that the Bureau of Applied Social Research has been conducting during the past three years. One is a study of the role relationships of ministers and psychiatrists. It also is an inquiry into the motivation of ministers to undertake pastoral counseling and of psychiatrists to become interested in using religion within their therapeutic work.

Another project has studied the clients of religio-psychiatric clinics: asking why people choose to come to a minister, how such people differ from those who take their problems to a psychiatrist, whether there is a particular sector of society that supplies the clients of a religio-psychiatric clinic, and so on.

In a third project, under the name of "The Social Psychology of Faith," the attempt has been made to prepare for evaluation of therapy or pastoral counseling by conceptualizing what happens in these processes in religious terms.

The Bureau, aware of the problems of measurement mentioned by Dr. Allport, has also been engaged in methodological research. The problem is regarded mainly as being in the area of indicators and concepts. It arises from the different approaches of psychologists and sociologists. The psychologist feels confidence in his observations of behavior, and is much less confident about the hypothetical constructs he would derive from these observations; the sociologist starts out with all sorts of hypothetical constructs and looks for the behaviors of which they would be good indicators. The Bureau's investigators have been trying to resolve some of the difficulties of the problem.

A bibliographic study conducted by the Bureau has been of considerable use. It has resulted in an almost complete list of the books published on religion and psychiatry during the last sixty or seventy years, with a brief annotation for each one as to content of the book, and some vitae about the authors.

The bibliography lists 1,347 books and articles The rate of increase itself is interesting From 1918 to 1927, only 59 items were published, in the next decade there were 135 items published, in the following decade, which included the war years, the number was 217; in the postwar decade the number grew to 837 Plotted on a logarithmic basis, the figures showed the expected straight line, indicating that there was indeed a logarithmic increase

During the period in which publications on religion and psychiatry or psychology—the overlapping field—increased from 59 to 837, publications on religion alone increased by one-third or somewhat less; publications on science doubled, publications on psychiatry doubled, and the total publishing output in the United States increased by a factor of one-half These figures indicate that publication in the overlapping field of religion and psychiatry or psychology is growing at a much more rapid rate than is publication in many other fields and publication in general

As for the religion of the people who are writing in this area, 58 per cent are Protestants, 32 per cent are Roman Catholic, and 10 per cent are Jews These figures vary in different countries In the United States, there are many more Protestants—71 per cent. About the same proportion exists in Germany In England there is proportionately more participation by Roman Catholics in this kind of writing. 45 per cent of those who write in the area are Roman Catholics Among the Protestant denominations, the interest is not evenly divided Many such writers are Episcopalians, with some Lutherans, Methodists, Congregationalists, and Presbyterians, but few are Baptists and members of such denominations as the United Brethren The interesting fact is that the pastoral counselors who write these books and articles come from the same sectors of society and the same religious background as do the psychiatrists The activity in this kind of writing, therefore, seems to be emerging in parallel lines in the two fields of religion and psychiatry

In an analysis by profession, the figures show that 67 per cent of the contributions are written by ministers, 21 per cent by psychiatrists, 8 per cent by psychologists, and 4 per cent by philosophers, journalists, and others The proportions differ among countries In the United States, 69 per cent of the writers are ministers,

whereas in Germany only 31 per cent are; that is, almost two-thirds are psychiatrists. In France, it is almost entirely a movement of Roman Catholic priests. The figures vary also in time; the Protestants entered the field earlier than did the Roman Catholics and considerably earlier than the Jews. Around 1910, for instance, it was a more heavily Protestant field than it was later. The ministers were working in the field earlier than were the psychiatrists. The proportionate participation of psychiatrists is increasing as time goes on.

There has been a shift of interest, Dr. Klausner continned. The earlier writings were largely theoretical, dealing with problems of theology, the theology of mental illness, and so on. Then there was more interest in practical problems of counseling. Still later, more was written about problems of role relationship, which is the latest direction of interest. As psychiatrists and ministers are making more and more contacts with each other, the role problem takes on more importance.

As for types of participants in the field, the Bureau followed the classification of Robert Merton.[6] The ministers and psychiatrists writing in this area were regarded as deviants: i.e., the ministers were moving away from the ministerial role into that of pastoral counseling; the psychiatrists were deviating by moving closer to religion.

Among the ministers, using Merton's terms, there are first the ritualists: those who follow the practices of religion but who, when asked why they do it, state their goals in psychiatric or mental health terms. For example, if one asks them why they pray, they answer, "Prayer is good for the health." Next, there are the innovators, who may be found practicing psychology or psychiatry as therapists. When asked why they do this, they answer, "It is a shorter road to salvation." Then there are the full-fledged rebels, who practice both psychotherapy and counseling and say they do so for the sake of mental health. The three groups have emerged in that chronological order—ritualists, innovators, and rebels.

The same types are encountered among psychiatrists. The ritu-

[6] Merton, Robert. *Social Theory and Social Structure.* Chicago, The Free Press, 1957.

alists are by-and large Roman Catholic psychiatrists, who practice psychotherapy in the psychotherapeutic tradition, but when asked why they do it give reasons in terms of moral qualities or salvation The innovators have stopped behaving exclusively like psychia trists, in addition to practicing traditional therapy, they will pray with their patients When asked about this, they will say that it is in order to help the patient overcome some of his paranoid delu sions, or to help him get back to mental health The rebel psychia trists have departed from psychiatric methods and goals They are some of the more religious oriented people in existential psychia-try

Asked by the Chairman whether the data collected and classified by the Bureau of Applied Social Research showed whether, as is sometimes suggested, the proportion of psychiatrists among Jews is much larger than in the general population, Dr Klausner replied that he and his colleagues had not made a general sampling of psychiatrists In studying the structural motivations for the recent movement of psychiatry and religion toward co operation, they had found elements suggesting that just because so much of psychiatry is Jewish, there was a growing feeling of need for Christian psycho therapy There is, therefore, a seeming paradox pastoral counselors emerge in a society not at points where there is a lack of psychi atric services, but rather where there is a good deal of that service, as in the urban centers

Dr Fremont Smith remarked that he noted a tendency to think of individuals as entities instead of as processes The process of being a human being begins with the union of the sperm and the ovum Why not consider how to deal with the problems of spiritual values from the earliest beginnings of the human being through to old age? The ootogenetic aspect of the problem seemed to him to deserve attention Perhaps there is a basic unity, perhaps biology and spirituality start as one and remain so This would mean that the dichotomy of religion and mental health is imposed by adults who look upon themselves and each other too much as entities

Chairman Klineberg commented that this idea had been dealt with quite fully in the symposium of 1958 This group was con cerned specifically with the way in which the sociological approach to religion and mental health can be helpful Dr Mead questioned

the accuracy of considering "religion and meotal health" a dichotomy. She uoderstood thc Academy to mean that the two terms represent two approaches to human problems that overlap, or are either supplementary or sometimes complemcntary. Mr. Anderson corroborated her interpretation.

Mental Health and Religion: Social or Personal Phenomena?

Turning back to Dr. Parsons' statement about the recognition that both mental health and religion are partly societal and partly nonsocietal and the tendency to assimilate them into the societal, Dr. Kolb asked whether religion and psychiatry are primarily and only societal phenomena or personality phenomena in a purely functional and determioistic sense. He quoted Kingsley Davis in his book *Human Society*,[7] writing of the fuoctional necessity of religion, as saying that it is made possible by social interaction and made necessary by the cxigencies of the social system. Bateson and Ruesch, in their work on communication in psychiatry,[8] think of the psychiatrist as holding the culture of the society up to the patient until he recognizes how desirable it is and returns to conformity with it instead of deviating from it. Dr. Parsoos, as Dr. Kolb understood him, seemed to feel that psychiatry and religion are important to the functioning and stability of societies, but are also something more. In his book *The Structure of Social Action*,[9] Dr. Parsons, commenting on Durkheim's view that religion and morality are essentially social phenomena, says that perhaps ooe should say society is a religious and moral phenomenon.

Presuppositions about the Image of Man

This, Dr Kolb suggested, raises the issue of the theoretical frame of reference within which the whole problem is approached what is the fundamental model of man, or the conception of the nature of man and the human condition? He believed that sociologists and psychiatrists work within a set of presuppositions that are basically naturalistic, arguing that nothing exists except in the realm of nature, that any belief system that goes beyond the realm of nature is illusory, although it may be functional, that such a system is deterministic, denying freedom and responsibility to the human individual, and finally (this is particularly true of sociologists) that this determinism is socio cultural in character, tending to make religion essentially a societal phenomenon

If society and personality are to be regarded in some sense as moral and religious phenomena, rather than religion and morality being regarded as purely societally- or even psychologically determined phenomena, then the nature of man, Dr Kolb thought, must go beyond the image of man apparently implicit in what Dr Parsons said This raises the question of whether purely naturalistic and deterministic presuppositions are adequate Dr Kolb suggested, therefore, that if we use an image of man that represents him as free and responsible, that recognizes the possible existence of a nonempirical realm, that does not regard beliefs in that realm as illusory, and that does not come down to a socio cultural determinism, and if at the same time we keep our concern with history and the importance of the empirical phenomenon, we are operating with an essentially Judaeo Christian image of man This in turn relates to the question of treating religion in the mental health area With this image of man, it is not reasonable to regard religion primarily as a tool for the attainment of mental health, for this would be to regard the actor's ultimate concern as a tool for the achieving of an end set by the observer's ultimate concern

Dr Kolb expressed concern over the fact that frequently, in con-

ligion is socially necessary, that its existence is primarily explained by this fact, and that it is one way in which social groups are made cohesive Two considerations that are obvious to the sociologist are in opposition to this view one is that it is not true that it does not matter what the religion is Any serious historical and comparative study, including study of nonliterate societies, shows important and intimate interrelations between the kind of society and the kind of religion The other consideration is that people who argue this way overlook the occasions when religious movements that have had the complete devotion of profoundly religious people have been socially disruptive in the highest degree It simply is not true that religion is a mild social sedative These two statements do not imply that there is no truth in the point of view of functionalism, on the contrary, Dr Parsons believes there is a substantial amount of truth in it

Chairman Klineberg asked Dr Parsons to cite an example of the disruptive force exerted by certain religious attitudes Father Salman interpolated that many people ascribe the fall of the Roman Empire to Christianity Dr Parsons declined to go that far, but he agreed that this opinion was held The Anabaptist movement in the Reformation period was an example, he suggested

Relation of the Specialist to a Discussion Group

The points of view from which Dr Kolb and Dr Fremont-Smith had spoken suggested to Dr Blizzard that, though it is easy to be aware of reductionism within philosophy and in philosophic terms, it is not easy to be aware of the fallacy of reductionism within sociology or psychology or psychiatry Chairman Klineberg asked whether by reductionism Dr Blizzard meant explaining a phenomenon by a cause at a lower level of complexity Dr Blizzard said he did not, that reductionism explains the totality of the phenomenon, all other factors are subservient "Nothing but," suggested Mr McCormick, with which Dr Blizzard agreed He con-

becomes relevant to a social understanding of the person in his tradition In this living community to which man belongs, as the Judaeo Christian story shows, religion is either intensely personal or it is nothing at all

Here Dr Oates referred to the Kinsey reports as one piece of research producing evidence that religion plays a part in the behavior patterns of people One of the impressive things about those studies, Dr Oates felt, was the way in which Kinsey and his associates pointed out the distinction between the internalized, personal, participating relationship of the individual to religion and the external, impersonal, nonparticipating relationship to religion In the latter instance, religion had little or nothing to do with the person's sex behavior pattern, in the former instance, it was tremendously powerful in nffecting behavior

Factors Affecting Psychiatry and Pastoral Counseling

Father Bier returned to Dr Klausner's statistics, in which there appeared to be some inconsistency in this respect they had indicated that pastoral counseling and psychiatry came from the same segments of the population on the one hand, and yet pastoral counseling was predominantly a Protestant movement, whereas psychiatry was largely a Jewish movement How, Father Bier asked, can one reconcile the statement that these two functions come from the same segments of the population with the fact that their practitioners do not bear the same proportions to the populations? Dr Klausner replied that he meant that the same kinds of underlying social forces apparently give rise to psychiatry and to pastoral counseling For example, both forces arise primarily in industrial societies Neither psychiatry nor pastoral counseling exists to any extent in Spain or in the Arab countries, they both exist side-by-side in the United States, in England, and in Germany

The fact that psychiatry is heavily Jewish Dr Klausner attributed

to historical reasons, though he thought it not correct to say that all of psychiatry is Jewish. Looking at the religious affiliations of psychiatrists, one finds that the Jews are more numerous in the psychiatric traditions close to the Freudian and neo-Freudian, whereas the somatically- and neurologically-oriented psychiatrists are considerably less Jewish. The fact that the "talking cures" are very Jewish seemed to Dr. Klausner to be a historical accident of "Apostolic succession." The fact that Freud was a Jew is associated with Jewish psychiatry and had something to do with producing other Jewish psychoanalysts.

Taking up the cultural aspect of the situation, Dr. Klausner said that opposition to psychoanalysis on the basis of its being deterministic, positivistic, mechanistic, and so on might have been found equally in any religious group. Judaism, Protestantism, and Catholicism all might have opposed it on these grounds. The fact is, however, that the leading opposition to psychoanalysis, especially in its early days, was primarily Catholic, secondarily Protestant, and hardly at all Jewish. Other members of the symposium added that opposition had been conspicuous among the Soviets and the Nazis, too.

Dr. Klausner thought it curious that there had not been opposition to psychoanalysis from Judaism. One reason, of a negative sort, was probably that so many psychoanalysts were Jewish. "But didn't the earlier psychoanalysts get into conflict with the leaders of Judaism?" asked Dr. Parsons. "Most of them were out-and-out secularists." Dr. Klausner replied that the Jewish opposition did not become marked until Freud published his *Moses and Monotheism*.[12] As long as the question was only that of "the future of an illusion," the problem did not seem to arise; but when monotheism was involved, anti-Freudian Jewish literature came out.

Another element in the attitude of religious groups, Dr. Fremont-Smith suggested, might be the mental health aspect of the confessional. Perhaps the Catholic Church did not need psychiatry in the early days because of the positive force for mental health it had in confession.

[12] *Moses and Monotheism* published in the United States by Alfred A. Knopf in 1939; parts I and II published in German in *Imago* in 1937.

Role Relationships between Religious and Mental Health Counselors

Father Mailloux cautioned against confusing mental health functions and religious functions Pastoral guidance may help a person in matters of conscience, but it will not cure mental illness The mentally ill may react to religious instruction or spiritual guidance, but they will remain mentally ill If, for example, a sexual deviant or an antisocial person has a delinquent attitude, that attitude has to be changed in some other way Dr Fremont-Smith asked whether Father Mailloux did not consider that the confessional experience is enormously helpful to many persons who are not psychotic or deviants, but who are emotionally disturbed or unhappy Father Mailloux replied that even a mild neurosis is symptomatic, unconsciously determined behavior, and that although a person with such symptoms may be helped spiritually or religiously by the confession, the mental health value of the sacrament was still doubtful He recalled Dr Allport's emphasis on the importance of the individual's attitude toward religion One must consider the person's religious experience A child or an underdeveloped person has a religion that is at the same level of development His religion may help him, improve his motivation, or give him some spiritual aspirations that will redirect his behavior somewhat; but it can hardly change his inner attitude, he is functioning at the same low level in every respect Father Mailloux thought it would be most interesting to study the religion of deviant or underdeveloped persons Meanwhile, Dr Klineberg asked, did Father Mailloux think such people needed both confession and psychotherapy? Father Mailloux said he did indeed In another conference in which this problem of attitude was being discussed, Father Mailloux had asked the psychiatrists present whether they had ever analyzed the attitudes of unscrupulous or deviant persons toward confession No one had Father Mailloux felt sure the attitudes of such persons would prove to be very infantile

Father Salman, expressiog agreement with what Father Mailloux

had said, remarked that all the emphasis seemed to be on the person who is sick. He wanted to consider the function of education, in which confession and general spiritual guidance can help prevent these illnesses, which, once they occur, certainly need specific treatment. Asked by Dr. Klineberg whether he did not agree that we need to know more about what the confession means to the individual's mental health, Father Salman said that he did, but that he was talking especially about the normal person who needs not therapy, but education and religious direction.

The points made by Father Mailloux and Dr. Oates prompted Dr. Parsons to add that there is a fundamental difference between the role of the psychiatrist, which has grown out of the physician's role, and that of the minister of religion, which goes back to the importance of the religious community, a historical development common to Judaism and all branches of Christianity. The clergyman is the responsible leader of a congregation, of a religious group with certain commitments and functions to perform communally. The ritual is the center of this activity. The clergyman is also the primary authority in another aspect of religious life: the doctrinal and moral discipline. This is true even in a system in which the minister is elected by his congregation. The role of the authority figure in this sense is fundamentally different from the role of the therapist, who is able to segregate the patient from his involvements in a social setting. Even with the development of group therapy, the fundamental reference point for psychotherapy is the physician-patient relationship. The physician is not the spokesman for an organized group as is the minister. This is an important difference, Dr. Parsons believed.

Father Salman suggested another important difference. The minister or priest is the shepherd of his flock; he is responsible for each member of the flock, and rejoices for the single one who is saved. This is an additional responsibility for the priest. Dr. Klineberg asked whether the psychiatrist does not also have a responsibility, whether if a patient of his does something wrong he does not feel guilty about it. Father Salman replied that the psychiatrist is responsible if the patient comes to him; he has no duty whatever to look for the patient. "This is fundamental," added Father Salman.

Going back to the remarks made by Dr. Fremont-Smith and

Father Mailloux about the confessional, Father Bier said be considered it extremely interesting that a psychiatrist should claim for the confessional more therapeutic value than a priest was willing to accept for it This kind of interchange of opinion seemed to Father Bier a valuable feature of conferences like this one

To Father Ewing, the relation between the two functions of the moral counselor and the sacraments of the church on the one hand and the psychiatrist or psychologist on the other seemed quite clear Recent advances of science now enable us to see the differences between the two factors involved, both together and individually To illustrate, be told about a highly neurotic, though not yet committable woman he bad counseled recently Realizing that she needed psychiatric help but that she would not follow his advice to seek it, he had reprimanded her forcefully about her unchristian behavior He believed his "laying down the law and the moral" might do a little good But this was only because (a) the woman was an Irish Catholic, and hence might listen to a priest, and (h) because this was a short term project, designed to relieve her son rather than herself It is often one thing to realize the symptoms and the need for psychiatric care, and quite another to get the patient to the doctor He agreed with Father Mailloux that the confession deals with the moral side of the individual's problems, and that psychiatric therapy is just as much needed for emotional disturbances as is medical attention to physical ailments He believed that a clergyman who is aware of the benefits of psychiatry and psychology can use them appropriately to bolster the moral assistance or advice he gives, just as the missionary uses knowledge of agriculture or medicine to help the people he is working with No dichotomy is involved, because the priest is dealing with the whole human being

Chairman Klineberg, seeing the points made by the recent speakers as having to do with the current interest in role relationships between the minister and the psychiatrist, asked Dr Klausner whether he could add anything to the discussion of this subject.

First, there are the problems arising out of ministers and psychiatrists getting together, said Dr Klausner Who does what? There is little doubt that the area of the organic belongs in the psychiatrist's role In the psychological area, however, there is a good deal

of competition. Extremists among the clergy and the psychiatrists will say, "My role can do the whole job." This amounts to a kind of reductionism on both sides. Or a physician may say, "A clear line must be drawn between what the minister or priest does and what the psychiatrist does." The sociologist tries hard not to get into the substance of the argument, but to find out which people are saying what and where they are located in the social structure.

There are considerable differences in this respect, Dr. Klausner continued. The position of clear isolation of the two roles is most prominent among Catholics, in the writings of the priests and theologians, and of the psychiatrists. This is understandable, particularly from the psychiatric point of view; accepting this kind of position is about the only way the psychiatrist can get along with the Catholic Church. On the other hand, many Protestant ministers maintain that there is very little difference, that the psychiatrist and the minister do pretty much the same thing.

Dr. Blizzard added that a reading of the history of the Protestant clergy for the three centuries prior to the present one shows that the chief role the clergyman played was that of preacher and authority-figure in his flock.[13] In this century, there has been a change among Protestants. One way in which the clergy are managing to sustain themselves within their parish is by means of the shift from the preacher roles being dominant to the pastor-counselor role being more important. They are trying to function as pastors, as counselors in their flocks. They are inclined to be more democratic, more permissive in their relations with lay parishioners.

Remarking that whenever sociologists expose themselves to a hostile world they get into trouble with the concept of the group, Dr. Sills re-emphasized the point made earlier by Dr. Parsons when he said that religious institutions are oriented toward the group, whereas psychiatry is oriented toward the individual. Dr. Sills thought this might account for the phenomenon of religious counselors like Norman Vincent Peale: people in need of *individual* direction go to *religious* institutions for it.

The kind of religious institution that often attracts the greatest number of persons is the one that seems to offer this attention to

[13] Niebuhr, H. Richard, and Williams, Daniel B., eds., *The Ministry in Historical Perspectives*. New York, Harper and Brothers, 1956.

the individual On the other hand, the number of people who are structurally driven toward a religious institution as a group, because of the many changes in our society, has diminished The very fact, therefore, that ministers now feel the need of psychiatric training is a recognition of the further fact that the church has to change somewhat its historic orientation toward the group rather than toward the individual Whether this is good or bad or helpful for mental health is something that can be discussed, Dr Sills concluded

The psychotherapeutic personality should be recognized in this connection, Dr Mead said Such persons are found in all cultures and in all sorts of occupations, perhaps a little more frequently among clergymen, physicians, teachers, and those who have accepted a vocation to do something with others But they may be found also as blacksmiths, grocers, and in many other vocations They have a kind of relationship to people that is helpful They are good for people who are upset, without necessarily using any very highly technical methods It is sometimes said that going to a psychiatrist is "going in and talking to somebody who likes you" Dr Mead considered this nonsense, for a good many psychiatrists plainly do not like their patients and are not particularly comforting to talk to The psychiatrist is a highly skilled person who knows something about the nature of psychoses and neuroses, about the symptoms of these illnesses and how to treat them His task is, as Father Mailloux said, quite separate from that of the religious counselor There are also many priests who exercise a therapeutic function in addition to their religious function Dr Mead said she had met people with this innate therapeutic ability in every human society she had ever been in

From the point of view of time and quality rather than of quantity, Dr Kolb said, one finds that some of the most searching criticisms of psychoanalysis in recent years have been made by people thoroughly familiar with the Jewish tradition He was thinking particularly of Philip Rieff and Irving Kristol and the man who wrote the book on *Freud and the Jewish Mystical Tradition*[14]

[14] Bakan, David *Sigmund Freud and the Jewish Mystical Tradition* Princeton D Van Nostrand, 1958, Kristol Irving, "God and the Psychoanalysts," *Commentary* VIII 1949, 434–43, Rieff, Philip *Freud The Mind of the Moralist* New York, The Viking Press, 1959

Another point Dr. Kolb wished to emphasize was that it is not just a matter of the priest filling one role and the psychotherapist another. The content of the knowledges applied and the frames of reference in which they are applied are important; if content and frame of reference are incompatible, there may be a crossing of functions. As an illustration, he told of having taken part, with two Protestant ministers, in counseling a group of young engaged couples in a Southern community. The two ministers talked purely naturalistic, deterministic sociology of the family to the students. They almost advised them to marry by questionnaire, to be sure to avoid marrying a neurotic, not to marry across class lines, and so on. Dr. Kolb alone had tried to relate the Judaeo-Christian tradition to sociological knowledge. Not only values are involved in counseling of this kind, but especially the basic conception of man. These ministers, he believed, without being aware of it, were basing their advice upon a totally deterministic image of man as a person who is, at most, capable of adjustment rather than as one who could conceivably overcome obstacles. There is not only a matter of ethics here, Dr. Kolb thought. If one thinks of man only as fitting into a group and never being able to transcend it, this is the kind of counseling or psychotherapy that results, whether it comes from a minister, a psychiatrist, a sociologist, or any other kind of professional adviser.

An Anthropological Approach

Discussion Leader:
MARGARET MEAD, PH D

Discussant:
THE REV J FRANKLIN EWING, SJ, PH D

An Anthropological Approach

Opening Remarks by Dr. Mead

Anthropologists at present view religion as something that is found in all human cultures It is an essential part of humanity, not just an essential part of society, in the sense of the naïve functionalism that was discussed in the Friday evening session, but a segment of human experience that is recognized in every human culture up to the present Of course, it is impossible to predict whether or not man may invent a culture without religion, he has not yet done so This includes the Soviet Union, where vigorous attempts to get rid of religion have ended up with treating history as a supernatural force

There are a few bits of puzzling information, some coming from archeology Though no traces of buildings associated with religion have been found in one area in India, for example, we know this may not be significant, because it is possible to give religion so many different settings Allen Holmberg's study of the Sirione Indians [1] with hardly any religion in South America does not make it clear to what degree these people were degenerate, certainly they have been reacting against all forms of higher civilization they have come in contact with for a long time With limited knowledge of their language, Holmberg did not find anything that could be called even a primitive religion But neither he nor other anthropologists feel that this is definitive in the present state of research in this area

[1] Holmberg A R., *Nomads of the Long Bow the Siriono of Eastern Bolivia* Washington D C., Smithsonian Institution, Institute of Social Anthropology, Publication No 10 1950

Anthropologists, therefore, unlike many other social scientists, do not look upon religion as a vanishing phenomenon; rather they expect it to take new forms of intensification at any moment in any society, although they find transitional points where secularism reaches a fairly high level.

I am going on with the distinction I made last night between scientific knowledge and therapeutic ability. I regard psychiatry as a branch of medicine using scientifically acquired knowledge to heal the mentally ill or to establish forms of society that will serve as preventives of mental illness. Therapeutic ability, which can be found in any culture and in any kind of person, is often, though not at all necessarily, embodied in religious practices or rituals. It is common to talk of shamanistic practices as having therapeutic value. In primitive societies one can find shamans who do bring people out of fits, or allay extreme anxiety, or do other things that are done under a psychiatric heading in our society. One can also find, in primitive societies, shamans who do not do these things. Working in the society, one usually finds that the shaman who is successful, the one to whom people who are accusing themselves of witchcraft go, is the kind of person who may be called the therapeutic personality, not in any particularly mystical sense, but simply as one who is able to give others a considerable amount of at least temporary reassurance and support. When a psychiatrist goes into a primitive society and says he is going to ally himself with the shaman to accomplish his purpose, he may have found a shaman who is a warm and supporting person, or he may be recognizing that some supportive behavior is often represented in ritual behavior, though it may not be the core of religion at all. A religion that includes confession, for instance, may afford relief to a person who is suffering from strong self-persecutory delusions.

The best study in this field that I know of is one made by Margaret Field,[2] in which she compared the histories of African women who go to a special practitioner to accuse themselves of having killed members of their families by witchcraft and those of women patients in an English hospital suffering from involutional

[2] Field, Margaret, "Religion and Medicine of the Ga People." *Journal of Mental Science*, October, 1955.

melancholia The two kinds of disturbance are almost identical in form The English woman with involutional melancholia says things like, "I wanted to strangle my son, and now I want to strangle myself", the African woman says things like, "I did kill my son by witchcraft" The self-accusations, the self-persecutions, are very similar In neither case is it assumed that there was a reality situation The African witch doctor sends more people home cured than does the English hospital, though not primarily for the sort of deeply religious reasons discussed in the Friday night session He has certain mechanisms of reassurance that have been elaborated through the ages

A cross-cultural survey provides a good deal of information about what sorts of symptomatology appear to be common to the human race and what kinds of mechanisms are found everywhere, in both primitive and complicated circumstances This is a fairly useful corrective to the statements made about particular religious systems today being responsible for particular kinds of symptomatology, the primitive counterparts of these kinds of symptomatology can be found easily enough For example, I studied a group in New Guinea in 1928 [3] in which the mechanisms of continuous guilt, compulsive confession, and compulsive attempt to atone for guilt followed all the patterns of compulsive neurotics in our own society and were utilized by the New Guinea society as they have sometimes been used in religious systems here Also, by means of a general survey of the world one can get some notion of what symptoms are dependent upon particular cultural conditions and can, therefore, conceivably be prevented by a rearrangement of our institutions, and what kinds of behavior occur only at certain phases of historical development [4] or in certain parts of the world A conspicuous symptom that has been well described is the one called "latah," or Arctic hysteria It is seen in a fairly continuous distribution from the Arctic down to Indonesia and Malaya, sometimes reportedly manifested by Europeans who live for a long time in

[3] Mead Margaret *Growing Up in New Guinea* New York William Morrow, 1935 Also printed in *Mentor* 1953 and reprinted in *From the South Seas* New York William Morrow, 1939

[4] Worsley P, *The Trumpet Shall Sound* London, MacGibbon and Kee 1957

Indonesia; it is not found outside this area. Apparently, therefore, the cultural mechanisms for its perpetuation need to be present before individuals who have a capacity to show this type of behavior will display it. It takes the form of a compulsive imitation. For example, if a person were carrying a beautiful glass goblet of priceless worth and someone were to drop a paper cup in front of him, he would drop the goblet. The behavior is elaborated in all sorts of ways, but apparently in only a special region of the world.

The question whether the same sorts of extreme behavior would be regarded as aberrant in all cultures and religious systems was one of the first points of interest in the area of culture and abnormality. Ruth Benedict wrote a famous paper in the thirties [5] in which she pointed out that people engaged in various widespread religious practices and using mechanisms that would be regarded as psychotic behavior in some societies were honored as visionaries, ecstatics, or hermits in others. The values placed upon different sorts of behavior vary from one society to another. Interesting work is being done in this field at present by George Devereux,[6] who is studying the problem from the disciplines of psychoanalysis and anthropology. He claims that, although these religious practices are differently valued in different societies, the mechanisms do not differ. They may be exactly the same as mechanisms that in our society would be considered psychotic or neurotic, but in the society in which they are manifested the individuals who suffer from these play a different role. If one is talking about simple indices of mental health, therefore, from the standpoint of psychological mechanisms, one can find societies that give high honor to types of behavior that we, with our strong emphasis on adjustment and conformity to norms, would consider mentally unhealthy, although the persons exhibiting this behavior may be socially valuable.

We can do a good deal with cultural material and scientific information. With the available knowledge of points of vulnerability

[5] Benedict, Ruth F., "Anthropology and the Abnormal." *Journal of General Psychology*, 1934, *10*, 59–82.

[6] Devereux, George, "Normal and Abnormal: The Key Problem of Psychiatric Anthropology." In *Some Uses of Anthropology: Theoretical and Applied*, J. B. Casagrande and T. Gladwin, eds. Washington, D. C., Anthropological Society of Washington, 23–48.

in the individual's life, we can adjust particular cultural demands that become too difficult for people at different periods of life For example, the Roman Catholic Church allows dispensations in fasting when food is scarce or in areas of poor nutrition As more is learned about the nutritional needs of people at various stages of life, religious requirements can be adjusted to protect the vulnerable in a way that could not be done without that knowledge And as science reveals more about the pressures on the adolescent and the celibate, for instance, we may, without changing our basic religious practices, adjust these practices to ease the demands on such persons

I think we can develop from anthropological material a great deal more understanding of the universal human psychological needs and capacities that are met by religious experience There is a growing recognition of something called by a name perhaps more acceptable to religion than to science i e, "the cosmic sense" By this is meant the need of the individual to have a relationship to the universe [7] (I am saying "the universe" to use the widest possible term—one that will cover the simplest and the most complicated religions) The need for this relationship can be met by a culture in a shallow or a deep fashion [8] There may be periods when the definition of the person's relationship to the universe is superficial, unelaborated It will be a period of shallow religious life There can be great individual differences in this capacity, as in all other measurable capacities, so that in a society that requires intensity of religious experience and prepares people for it, some persons may suffer from a tremendous sense of alienation and loss because they cannot meet the requirements Conversely, in a society that has become increasingly shallow in its expectations of the individual's relationship to the universe, those with greater capacity will be penalized—perhaps even driven to mental illness by the fact that their society provides them with no spiritual nutriment

Anthropology contributes to the solution of this problem by

[7] Cobb, Edith "The Ecology of Imagination in Childhood." *Daedalus* Summer, 1959, 537–48

[8] Mead, Margaret, "Some Relationships between Social Anthropology and Psychiatry" In *Dynamic Psychiatry* F Alexander and H Ross, eds. Chicago, University of Chicago Press, 1952, 401–48

studying one culture after another, showing how and at what level the culture has been able to meet the needs it has developed in the people who grow up within it, and using the knowledge so obtained to widen understanding of human potentialities and to insist upon constancies. It had seemed useful to anthropologists to distinguish between great religions, with the capacity to transcend cultural boundaries, based as they are on a definition of man that is wider than any culture and forming as they do a kind of supracultural system, and primitive, provincial religions which are tied down in experience and time to a narrow definition of man, not viewing the whole of mankind as one.[9]

Remarks by Father Ewing

Religion, as an element that is intertwined with and fused into every portion of daily activity, is much more to the fore in the primitive, or as it is now more accurately called "nonindustrialized," society than in our technologically developed Western culture. Part of the reason for this is that every culture, or group of cultures, has a focal orientation. Just as an individual cannot be interested and active in everything all at once, neither can a group of persons belonging to a culture scatter its interests. The focal orientation can change: technology has become a great one in our world today. As one interest, or focal orientation, grows, something else must diminish. For instance, interest in the sacred fades into the background in big cities, where enormous practicality and anonymity characterize the individual's life. There is a correlation of some sort between the city's anonymity and dissocial unrigidity on the one hand and the sense of the sacred on the other, because the family is always a simple force tying in with religion.

Anthropological textbooks treat religion in various ways: as part of an explanation of the universe (the intellectualization of know-

[9] Mead, Margaret, *New Lives For Old.* New York, William Morrow, 1956, 435–38.

ing how the stars got up there or how the elephant got his trunk), as a matter of morale building when things seem too difficult for the individual and he has to call on the superhuman world (a sort of foxhole religion) The textbooks also make much of projection the spirit world is a sort of anthropomorphic projection of the living world and the human beings involved in it There is some truth in all of these views, but they do not add up to religion They leave out the basic sense of awe, the affective attitude toward the superhuman world, the question of a sense of personal dependence on the superhuman, and the difference between religion and magic, which I see chiefly as a matter of the propitiatory nature of the former and the compulsive situation in the latter Religion, as Dr Mead said, evidently is a basic need of the individual

Magic reminds me of something that is interesting me at the moment It ties in somewhat with the concept of the therapeutic personality mentioned by Dr Mead The average Western skeptical anthropologist explains the idea of magic very simply An African, for example, believes that if he is hexed, he will die Therefore, if he finds out that he is hexed, he dies This is not adequate to explain many phenomena that occur in the world and about which psychic research has revealed little On the subject of telepathy, for instance, I know of nothing really sensible that has been written, nor on the powers of certain people to do some spectacular things There was an interesting conversation between an Australian anthropologist and a couple of shamans, one of whom was more acculturated than the other The more acculturated one told the anthropologist about the tricks of his trade, which date back thousands of years He admitted that they were nothing more than tricks When the anthropologist asked him to whom he would go if he got sick, the acculturated shaman said, "To my colleague here" The anthropologist said, "But you just admitted that a lot of this was sheer quackery!" The shaman replied, "Yes, but you nced that, too"

A surgeon's habit of starting every operation by turning the scalpel once, ending up with the blade in the right place, may be called nothing but a motor habit that makes the surgeon feel better There is a preparation for the individual soul, even in an act of magic Observationally, magic and religion form a kind of spec-

trum; sometimes it is hard to tell which is which. I urge the missionaries I teach not to be too Western, too skeptical, about magic practices they may encounter, such as the pendulum and map operation; there are too many facts involved, too many cases of unexplained successful divination.

I would like to tell you about an experiment conducted by a student of mine in anthropology bearing on the mysterious powers of certain people. The young man filled a large glass jar three-quarters full of water. He sank in the water a piece of paper with concentric circles in a grid of quadrants, then covered the jar and let it stand a few hours. He put in the center of the jar the lightest thing he could find: a tiny seed. He covered the jar again and waited another hour. Having put the jar on a table that stood on a concrete floor, the student sat down well away from the table so that vibrations from his body would be somewhat remote, and willed the seed into the northwest quadrant. In about ten minutes he had it there, a distance of about two and a half inches. Thinking there might be a convection current, he willed it over into a comparable position in the northeast quadrant. That took about fifteen minutes. I questioned the young man about the experiment and could see nothing wrong with the experimental design. I suggested only that he should do it in the presence of witnesses and that he should do it several times. Such things, of course, are only straws in the wind, but they give one pause. Modern theology gives no credence to the practices of years gone by—the early fathers calling upon angels to move the stars and such things. The electronics of the brain, particularly for telepathy, are of such low voltage that one cannot span a thousand miles by this means. Which leaves what? It leaves the spiritual soul, with an ability, even while remaining in the body, to project its power somewhere or other and to do things with material objects. After thinking about the experiment I have just described, I have taken a different view of bonepointing in Australia: pointing a bone at the enemy to kill him. I do not know whether certain specially endowed persons are capable of such things or not, but I think the whole matter needs study. It is all related to what has been said earlier in this conference about religious experience. Such religious or magical ability is not the same as being a Catholic or other religionist—it does not indicate whether one has had real religious experience or is just

one of a great many human beings enrolled in some sort of organized religion

Deviant Behavior in Primitive and Industrialized Societies

Dr Mead remarked that in all the cultures she had worked in where there were institutionalized practices that might be regarded as suitable material for psychic research, the number of persons who appeared to be successful in such operations appeared to be in about the same proportion as they are in our culture There may be, for instance, a great many mediums, with only one who does something that cannot be explained, or there may be a number of people who go into trances to find lost objects, but only one the accuracy of whose behavior cannot be explained As nearly as one can work out proportions with such small numbers, these few successful persons seem to be in the same proportion in primitive and complicated societies Similarly, if one leaves out psychoses caused by syphilis and other such conditions, there is at present no good reason to think that there are more or fewer psychotics in the primitive groups than in our own society We can perhaps keep the more vulnerable people alive with greater success than the primitive people do, but that is the only marked difference Knowledge of primitive societies, therefore, does not add much to our knowledge of the possibility of different kinds of behavior that are at present inexplicable

Vision Experiences

Taking up the remarks made by Dr Mead and Father Ewing about forms of behavior that are so far unexplained, many of them related to religious practices, Chairman Klineberg cited the vision experiences of the Plains Indians and other more or less "primitive" peoples, visions that convince the dreamer that he has seen

the guardian spirit or some other supernatural being and that his life will be affected by the experience. "A kind of celestial vocational guidance," Dr. Klineberg called it, because the man is told whether to become a warrior or something else. Then there are, in our own society, believers, notably Catholic believers, who, through their church, know of visions and dreams that are frequently regarded as visions of a supernatural being or direct communication with the Supreme Being. When the anthropologist compares these two kinds of experience—the vision of the Crow Indian and that of St. Thérèse—what has he to say about the similarities and differences between them? Can the religious person draw a distinction between them?

Dr. Mead replied that the anthropologist, in her view, can do no more with such a question than the nutritionist can about classifying or evaluating the thoughts or hallucinations that may come into the mind of a severely undernourished person. Definitions of beliefs and their classification as true or false are content points that lie outside the area of the anthropologist. His business is simply to discuss the occurrence of such behavior and how widely it is found, to deal naturalistically and scientifically, but not mechanistically or deterministically, with the facts and how people react to them. Whether the vision of the Crow Indian or that of a peasant in Catholic France is true religion is not for the anthropologist to

area in which both the anthropologist and the religionist would have something to say

This raises two quite distinct problems, Father Salman observed There is no way for the theologian or anyone else to know whether a vision is a true one or not One can say only that it is in conformity with what is believed elsewhere within the religious group and that the person who has the vision, who is believed to be in touch with God in a special way, shows in his subsequent behavior some probable but distinct knowledge intrinsic to the vision The anthropological problem is to identify and describe the type of vision and its role in the relevant culture

The current discussion was especially relevant to a concern of the Academy, Mr Anderson said He had been working during the past three years with a committee studying the ministry as a vocation The members of the committee had found that many persons enter the ministry or the priesthood or the rabbinate because they have had a call from God or a vision directing them to do so The committee learned also that when the voice of God calls to the Catholic, it is to be a Catholic priest, to the Jew it is to be a rabbi, and to the Episcopalian it is to be an Episcopal minister Obviously this problem needs further study

Father Bier spoke of the difficulty encountered by theologians, certainly in the Catholic Church and probably in other religious groups, in attempting to evaluate such experiences as visions and other contacts with spirits The examples just mentioned by Dr Klineberg are among the most difficult to judge The Catholic Church purposely refrains from saying anything about the validity of the visions even of saints It is not against such things, but when it canonizes a saint it does not canonize his visions, one may think as he chooses about the visions

'Is the experience of the Crow Indian or of the Catholic saint or of any other visionary a religious or a psychological experience?" asked Mr McCormick Dr Watson suggested that in either case it is an experience and can be looked at from the standpoint of either religion or psychology, because both theology and psychology are developed systems of postulates and concepts that are interrelated, within these systems, one may look at any experience, ordinary or extraordinary, without putting the experience in any category

Dr. Fremont-Smith, referring to the point made in the Friday evening discussion that man does not *have* a soul, he *is* a soul, said that perhaps an equally tenable position would be that the dichotomy between the natural and the supernatural is false; that experience may have a religious and a psychological aspect, and also a physiological aspect. We certainly have not learned all there is to know about natural phenomena. No physicist has explained everything about the atom. On the other hand, if man is a soul, the supernatural is present all the time and there is no sharp distinction between the natural and the supernatural. Perhaps all aspects of man are supernatural in one sense. If we define the natural as what can be explained by natural laws and call everything else supernatural, then whenever a new natural law is formulated we find the ground cut out from under the validity of the supernatural. If, however, the supernatural is regarded as an intrinsic part of everything, it can never be undercut.

Dr. Blizzard noted that in considering the validity of religion, persons skilled in certain disciplines tend to move just so far in the understanding of religious phenomena, assuring themselves and others that they are holding to the boundaries of knowledge within their disciplines. Then everyone backs off and says, "If we can go only that far, we can't establish the validity of this experience or concept." Perhaps, he said, behind this kind of relativism is the kind of thing Dr. Fremont-Smith had been talking about; then, later, one may change the bounds of what religion is. At this point, we have disarmed one another, saying in effect that if we go beyond the normal limits of discussion within our discipline we shall be disloyal to it in posing questions that cannot be answered from its point of view.

Presuppositions about Symbolism

Dealing with the specific problem of the vision, Dr. Kolb said one might have to distinguish between the vision or other experience that began a particular religious tradition and one that

occurred within the tradition after it had been established as a cultural institution If that distinction is made, then when the anthropologist grapples with the problem, the way in which he does so will depend upon the presuppositions with which he begins

As an illustration, Dr Kolb mentioned the last two chapters of Warner's book on symbolism in America,[10] which are devoted to the theory of nonrational symbolism, including religion and the ology. Although Warner is interested in and sympathetic to this symbolism, Dr. Kolb believed that because one of his presuppositions is basically naturalistic, and because his model of man includes only rational or affective behavior, he has produced a projective explanation of nonrational symbolism Nonrational symbolism is essentially irrational behavior that performs an important function Dr Kolb mentioned other writings in which presuppositions or positions open up problems of sociological or cultural relativity in the authors' views of religion Finally, he said, one comes to the question of false visions, or idolatry, particularly if the conception of religion is broadened to include such things as Marxism or National Socialism In grappling with a problem of this sort, the social scientist is not called upon to evaluate it, Dr Kolb believed, but in dealing with the origin of vision experiences, one must take into account the frame of reference or the presup positions from which the social scientist approaches the problem

Rabbi Hollander remarked that people looking for mental health values in religion seemed to shy away from ascribing supernatural and transcendental aspects to religion This leads to an interpretation of religion on the part of some religionists and scientists that is purely rationalistic When they speak of the relationship of religion and positive mental health, they appear to he doing so solely because of religion's social contributions They do not take into account religion's unique role in helping man discover his ultimate place in the universe

Going back to Mr McCormick's question about whether a vision experience is a religious or a psychological one, Rabbi Hollander agreed with what Dr Kolb had said about the determining

[10] Warner, William L., *The Living and the Dead* New Haven, Yale University Press, 1959

role of the presuppositions upon which one bases his view. The religionist will have a presupposition about man and the universe that will determine his interpretation of the experience. Because of the difference between the presuppositions of the religious and the psychological points of view, it is impossible to merge the two.

Psychological-Theological Considerations in Vision Evaluation

Father Mailloux observed that the theologian should not forget to consider the thought processes involved in the visionary experience as a basis for evaluating its genuineness. Freud noticed that when unconscious repression takes place, the emotional impulse is cut off from the verbal image; the mental representations of an impulse become less abstract and rational and more like a visual image. The person turns back to fantasy. In a therapeutic process, Father Mailloux suggested, the person who is suffering from repression is given an opportunity to verbalize, i.e., to retranslate his incomprehensible fantasies into rational and meaningful words.

Freud also dealt with the need for a relationship with the universe when he wrote about what he calls the "oceanic feeling," Father Mailloux continued. A superficially comparable experience occurs both in the depersonalization process characteristic of schizophrenia and in some mystical experiences, although it has a totally different sense in these various circumstances. One may well conceptualize God as an ocean of perfection, an Infinite Being. In regressive thinking, the concepts or images involved may be apparently the same as those used by the theologian; but, while indulging in regressive thinking, a person confuses the symbols with reality, whereas the theologian regards them merely as analogical conceptualizations and through them integrates a whole theological train of thought.

A highly sophisticated theologian, Father Mailloux said, cross-examining a person who had had visions, might form a definite impression whether such a person was delusional or not. If not, in-

deed, one might expect that the visionary's answers would be in complete agreement with the tenets of revealed truth and theologically correct all the time, in spite of his complete lack of sophistication, his deep motives would be rational and theologically sound Therefore, the thought content and the underlying motivation are extremely important considerations in this connection

Recalling Dr Mead's statement that visions speak the culture of the persons who experience them, Dr Meserve said he had got the impression that there might be a universal kind of religious experience that was beyond all specific visions and not culturally conditioned He asked Dr Mead whether she had been hinting at this when she talked about the need for a cosmic sense that could be felt on both a very primitive cultural level and a very sophisticated level

Dr Mead replied that she had not been talking of anything as specific as visions There are societies in which nobody ever has a vision, visions are not within their developed psychological capability, unless a catastrophic event alters it Visions are only one possibility The kind of thing she was talking about was not based on regression She agreed with Father Mailloux that an experience can be seen in a regressive or a highly-developed form However, the distinction between the rational and the irrational was not the primary point in what she was considering She had been thinking of a sense in which the understanding of the individual's relationship to the universe grows and is part of the evolutionary process represented by human beings today It is something that is inherent in all individuals, but differently developed in different cultures at different periods

Use of Visions by Societies

Recollection of Jung's observation from his experiences in Africa that the natives distinguished between great dreams and ordinary dreams, the great ones being those that the whole council had to sit and think about, while the ordinary ones were those that any-

body could consider in his own way, prompted Dr. Watson to ask whether any anthropologist had studied the criteria by which societies that make use of visions sort out the significant ones from the trivial or misleading ones. He thought this knowledge might be helpful in thinking about the essentially religious vision.

The most extensive study of this kind, Dr. Mead said, was made by Kilton Stewart,[11] who is both a psychologist and an ethnologist. He investigated the handling of dreams in several primitive societies. In a pygmy group, all dreams remained at the level of the child's dream about ice cream and cake or "a big bogey is going to get you," or of adult dreams of the same order. In another group, dreams were recognized as somewhat important; an adult dream might be considered to have importance for the rest of the group.

A third society studied by Dr. Stewart had experienced dreamers, persons who had learned how to dream. If a dream could not be interpreted, was not related to what could be done or to behavior in the same sense that a vision is related to the behavior of a saint, it did not amount to anything. Prospective great dreamers would tell their dreams and the old men would discuss them and say things like: "I don't think much of this one; you should have come out of it with a way to carry things over a mountain better," or something of the sort. These discussions amounted to a kind of ecclesiastical college for the training of persons to have great dreams. In another tribe (the Iatmul of New Guinea) [12] people never told their dreams until something happened that was related to what they had dreamed; then the dreams were accepted as great ones.

One American Indian tribe, Dr. Mead added, practiced a vicious form of deceit on the religiously aspiring young. Publicly it was stated that anyone could have a vision, but actually there was a secret list of respectable visions. If someone who did not belong to the right family told the religious authorities about a vision he

[11] Stewart, K. R., *Magico-religious Beliefs and Practices in Primitive Societies: A Sociological Analysis of Their Therapeutic Aspects.* Unpublished Ph.D. thesis, University of London, 1948. See also Stewart, K. R. (in collaboration with S. D. Noone, Perak Museum), "Dream Theory in Malaya." *Complex*, Fall, 1951, 21–33.

[12] Mead, Margaret, unpublished field notes.

had had, he was just told that it was not a true vision A small group of families kept a hold on the correct visions [13]

Attitude of the Behavioral Scientist toward Religion

Dr Parsons returned to Dr Blizzard's comments about the position and role of the behavioral scientist in the attempt to deal with problems related to the place of religion in human life The psychologist or anthropologist faces his commitments as a scientist understanding that he is, after all, a human being with personal problems going over into the religious sphere He was brought up in a religious tradition and may have a particular religious affiliation The question of the basis of adequate objectivity in the Western world is particularly acute Orientals to whom Dr Parsons has talked about this problem have indicated that they are aware of it, because Western religions put more emphasis on their possession of exclusive validity than do Oriental religions The relation between scientific objectivity and personal or denominational religious commitments on the part of the scientist seemed to Dr Parsons to be a matter for serious consideration He thought it no accident that some of the most important contributions to the subject of religion in human life had been made by people who were denominationally uncommitted He cited Freud, Max Weber, and Emil Durkheim as scientists who, though admittedly they cared about religion, took essentially secular positions No high level study in this field can avoid the comparative reference, Dr Parsons said, and good comparative reference cannot start with the assumption that the other fellow is wrong

Dr Mead took issue emphatically with this view Good comparative work, she said, can start with the assumption that religion, including one's own, matters The behavioral scientist often is a

[13] Fortune, R F *Omaha Secret Societies* New York, Columbia University Press, 1932

humanist of one of two kinds: those who think science is a religion or those who think the humanities are a religion. Other behavioral scientists take a more conventional religious position. What frequently happens is that a behavioral scientist who thinks he has no religion at all, because he believes in nature or the goodness of man or something of the sort, tries to engage in detached, comparative work, when actually his work is firmly anchored in a truly philosophical religious position; or he has to pretend that he is a man from Mars, which is not true either.

In any group discussing religion, Dr. Mead believes, the behavioral scientist who is a humanist should be able to express his opinions. There should be also persons who are firmly anchored in their version of religious truth and who think all others are rudimentary, partially mistaken, or outright wrong, but who are interested in the behavioral sciences—persons concerned with religion as such and at home in a religious atmosphere. Then there should be people who consider religion something that the scientist cannot accept at all, who are deeply rooted somewhere else—in the goodness of man or the evolutionary process or something. With all these positions explicit, members of the group could use the methods of behavioral science equally well, without confusion.

Dr. Fremont-Smith suggested that the point was to make one's subjectivity overt and to attempt to compensate for it instead of making a pretense at absolute objectivity. This, he thought, was the essence of the true scientific position—recognizing that there is no escape from subjectivity. The questions to be kept in mind were: What is the subjectivity? How does one take it into account and balance it? How can one determine how much his particular subjectivity interferes with what he is trying to say, his particular experiment or data? He agreed with Dr. Mead, and thought that the real anchorage point was that everyone should make it known where he stands.

Dr. Mead further stated her view as meaning that in a discussion like the one in which this group was engaged, everybody speaks from a position on religion that is not a question of science. The position of any member may be antireligious; it may be one of complete naturalism. But every person in the discussion has some sort of position on religion. Mr. Anderson added that a belief built

into the structure of the Academy is that what a man believes is an essential ingredient in his health In this respect, one's belief is brought into direct relationship with clinical medicine In a sense, we are all theologians The word 'theologian" comes from "logos" about the "theos " "If, in your intellectual journey, you decide that you don't want to believe in God, this is still your theology, in effect, everybody here is a theologian "

Grappling further with the problem of the nature of individual religious feelings and commitments and the relative or absolute objectivity possible for the social scientist, Dr Hofmann and Dr Mead took different views of the nature of religion, Dr Mead declining to regard it as a social organization, but defining it instead as "that form of human culture that relates to the universe " "There have been," she said, "great social organizations built about religion, and there have been great religions that were not so organized " When she talked about people taking their positions, she meant not an organizational position, but a philosophical religious relationship to the universe

Dr Kolb added that, as he saw it, the scientist is committed to his presuppositions Such discussions as this one, therefore, with relative objectivity, could take place because there are certain elements common to the presuppositions of all members of the group, whether those presuppositions were naturalistic or something else One common presupposition is that empirical data are real and important "And that rational ordering of those data is possible," interpolated Dr Parsons "That is a philosophy, not a religion," Father Ewing observed Dr Kolb considered it a matter of commitment, and noted that the difficulty in this discussion seemed to be in the concern for certain other presuppositions about the nature of man and of the universe in which he lives and about the relation between man and the universe He returned to what he understood to be Max Weber's position as one takes different presuppositions about this question, one actually investigates different problems or orders the data in different ways, depending on the approach Dr Kolb called this a matter of religious commitment.

In connection with Dr Mead s view that all the positions represented were religious positions, Dr Klausner said the discussion

was merely moved to another level. One would then have to differentiate between the kinds of gods being worshipped—a Hitler, or history, or another kind of god. There must be differentiation between the religions of science and of nationalism. With the various types distinct, the discussion could proceed.

Evaluation of Miraculous Cures and Visions

Turning then to what Father Ewing had said about the various theories of religion being inadequate because they do not quite present religion, Dr. Klausner spoke of his experience on a recent visit to Lourdes. He had asked people in the medical bureau how they go about determining what is a miraculous cure and what is not. He had learned that they ask a series of questions to find out whether the cure can be explained by medical science. If it can, or if they are convinced that it is a hysterical cure, the case is eliminated. The cure that is called miraculous is the residual case. Critics of Lourdes can say of someone who was cured in 1860 that "they did not know about hysteria then." The process of evaluating is constantly being refined. New knowledge continuously changes it. The last step in the process is an ecumenical decision about whether the behavior of the cured person has been changed in any way. In his report on the experience, Dr. Klausner has suggested that miracles should be defined in more direct terms, and not as residual categories in theological terms.

As for the differentiation between a religious vision and the hallucination of a psychotic person, Dr. Klausner thought that taking into account the naturalistic presuppositions mentioned by Dr. Kolb, looking for external objects and trying to validate them makes the whole question insoluble, because it is impossible to validate a subjective experience. He believed that it is possible to regard visions as any other form of symbolism, to take an epistemological view of symbolism as being the way in which we organize our grasp of the world; the vision is one of the ways. As Father Mailloux had suggested, the vision experience may include regres-

sive elements, which Dr Klausner thought would arise from the organizing of motivational resources, that is, the person turns back in the organizing of his motivational resources, for the grasping of the world symbolically is equally an emotional grasping, condensing, and channeling of the motivational resources into the intended act If we want to decide whether the vision is valid or not, we must make use of criteria These could be based on the functions of the act or the particular system in which we are interested Theologians will judge the vision or religious experience on the basis of the kind of religious consequences

Dr Humphreys asked for a return to "suffering humanity" at this point—to people who are struggling in everyday life, who have tensions arising from psychoses or neuroses perhaps, or tensions arising out of the problems of growing up, of differentiation "Sometimes we have to regress, but how? Sometimes in the pathological sense But we can also regress in the sense of the old Taoist meaning of the return of the spirit to the primordial waters, wherein it can find a baptism and re-emerge " Dr Humphreys thought perhaps the current discussion might well attempt to make that sense of the cosmic order meaningful in relation to everyday life He suggested moving into the frame of reference that Jung called synchronicity, where one can look upon the causal world in one direction and on another type of reality in another This might help to pull together the many different kinds of reality in consideration of religion and psychiatry

Primitive Concept of the Why and How of Illness

Dr Allport based a question for Dr Mead upon his own limited experience with a primitive religion, remarking that, in one respect at least, religion seemed to come off better in relation to mental health than does modern American psychiatry With a Swedish mission in Zululand, he had observed the society in the bush far from any other Western outpost Excellent medical and psychiatric

care was furnished by the mission. Patients gladly came to it because the white men could mend broken legs and treat malaria, kwashiorkor, bilharziasis, and so on. But it was only a superficial technique. The real question in a case of suffering was "why did it happen?" So the native patients also consulted an isangomma who lived just outside the compound on the best of terms with the white doctors. While being patched up by the white doctors, the Zulus would ask this "smeller-outer" why their trouble had happened, and then they would go to a witch doctor in the vicinity to find out who had bewitched them and how to prevent it the next time. Their idea seemed to be that all the white man knows is how; he knows nothing about why.

Applying this experience to the current problem, Dr. Allport wondered whether it was possible to solve the problem of the relation between religion and mental health unless the practitioner—usually the psychiatrist—is willing to go into the problem of evil with the patient, to consider a philosophy of suffering, of explanation and acceptance. "Since the psychiatrist doesn't have the explanation for evil, he probably will have to turn to religion, which also doesn't explain evil, but at least tells how to get on with the morals." Dr. Allport asked Dr. Mead whether his observation that primitive people do not keep their "how" and their "why" in separate compartments had any validity.

It is impossible to generalize about primitive peoples, Dr. Mead replied. There are both how-oriented and why-oriented peoples. She had twice seen modern medical ideas successfully grafted onto a prepsychiatric society. The Manus people she had studied, even in 1928 when they were still completely pagan, never really asked any question except how—how to get well, etc. The "why" question was subordinate to the practical question of "how." These people worshipped the ghosts of their most recently deceased ancestors and explained all misfortune and illness in spiritualistic terms as completely as a Christian Scientist would. The only medical aid they would accept was the sewing of a wound. They regarded the soul as infinitely divisible; different ghosts could carry parts of it off in different directions, and the individual got sicker and sicker as he lost more bits. Twenty-five years later, the Manus had become Christianized and had absorbed a number of ideas of

higher religion They had got their soul together, they called it a mind-soul, a sort of combination of soul and brain It had integrity They also had acquired a respect for medicine They believed that unless one's mind soul was in the right relationship to God and one had the right medicine, one could not get well For example, if one was trying to care for a child with an extreme attack of cerebral malaria and the father and mother were quarreling, the religious commentator would say, "How can that medicine work as long as this kind of anger is in your heart?"

Two things could happen to these people they could be given the kind of theology that, in the hands of a native catechist, would exclude medicine, surgery, and all such things and would interpret misfortune as a punishment for sin—a theology that would fit into their old, unmixed position—or they could be given a form of modern materialistic medicine, which would tell them that the state of mind or anger in the heart had nothing at all to do with whether or not the aralen worked At this point they were vulnerable in both directions, but they themselves had made a synthesis far superior to the synthesis that most of us are able to make

In Bali twenty years ago—another illustration at quite a different level—there was virtually no modern medicine All treatment was either magical or religious The Dutch did not practice clinical medicine in the native communities, only mass preventive measures There was wholesale compulsory vaccination, which doubled the population, and there were offerings to the gods, sacrifices, ceremonies, pilgrimages, and various ritual ways of dealing with illness Today the Balinese have come into the modern world They have decided that there is such a thing as modern medicine, which includes treatment for the insane Instead of letting them live in a tattered state in somebody's kitchen or tying them up in stocks or trying religious methods of curing them, the Balinese now send them to a mental institution They have one of the best such institutions she has ever seen, Dr Mead said There is no psychiatrist, but there are good psychiatric nurses It is built somewhat on the order of the kind of community center provided by a Balinese temple complex Inside of it, patients, former patients, and families of patients have built a shrine where they express their gratitude Though considerably influenced by Christianity, the Balinese

are still Hindus. They say to the mental patient, "You have to go to a hospital; you have to have certain kinds of isolation and to be protected, gently." They have taken over the best of modern psychiatric care and combined it with a religious approach.

These people are vulnerable to the visit of psychiatrists who say, "What are you doing with a temple inside a hospital? We need an electroshock machine." The people are vulnerable also to anyone who may try to restore n belief that the best kind of treatment is the old kind—dependence on religious observance without recourse to any modern therapeutic device.

"We don't see really primitive people today," Dr. Mead said; "they would either eat us or take off our heads. We see societies in contact and imagine forms of primitive societies in which things are beautifully integrated." She did not see any reason to assume that such people have particularly good mental health, that living in fear of starvation, of one's enemies, of death from one cause or another at every moment would necessarily produce good mental health.

Dr. Allport noted that he had not meant to imply that they were healthy and happy; he had meant only to suggest that their integrated curiosity about the "how" and the "why," nbout the problem of evil, might shed some light on our own psychiatric care. Are we doing enough about the "why" in handling our own cases? Perhaps all cultures have a natural curiosity about the "why" of suffering.

Dr. Klineberg called this a very important problem. He thought the attitude toward illness of whatever kind might be determined in part by the interpretation of why it came about. Was it because the sick person was evil, or because devils or spirits outside were conspiring against him, or because God wanted to put him through certain travails as in the case of Job? The explanation given to the cause of the illness might have a great influence on the outcome of the process. Dr. Parsons added that the attitude toward doing something about the illness would also be affected by the culture's views of illness as a justified part of the order of the universe.

The observations of Dorothea Dix, the woman who did so much for American psychiatry in the last century by insisting upon the

separation of the mentally ill from the violent criminals, seemed of interest here, Dr Wolff said In her travels abroad to see how the mentally ill were cared for in other countries, she had found that the best psychiatric care was given by the Turks and the Russians The common feature in these two countries was that the mental patients were recognized as unfortunate and troubled human beings and dealt with in a kind, supportive way, allowed to live through their illnesses if they could, or kept from harm if they could not This seemed to Dr Wolff to have something to do with what had been said about the temple, even in our Western tradition, the mental hospital has only recently moved out of the temple in the sense that it is now full of gadgetry

Primitive Attitudes toward Death

Dr Wolff then asked Dr Mead whether the recognition of death as the inevitable fate of man plays an important part in primitive religions, if one can make such a general category Does the need for continuity seem to run through all mankind, and are the methods of supplying it mere variations on the way of dealing with death?

In reply, Dr Mead said that the idea of how death came into the world is a part of the whole question just raised by Dr Kline-berg—whether death is a recent intrusion into the world, before which men lived forever This theological problem is raised in various cultures If death is so regarded, then it is interpreted as a punishment One finds people who have almost no sense of personal immortality at all—only a sense of the immortality or continuity of the universe, of which man is a transient part They believe that "man grows up in the morning like grass and at night is cut down " Their idea of life after death is very shadowy, rather unrelated to reward and punishment At the other extreme is belief in reincarnation, which is found in many parts of the world The segment of life one lives in may be extremely determinative of

the next segment; it loses the degree of importance it has in those religions *that believe that man has only one life, one* chance to work out a relationship to the universe, which then becomes final. As an English archbishop has phrased it, "The duty of earth is to colonize heaven." Between these two extreme sets of belief, Dr. Mead said, one finds no people who do not recognize death as a reality. In fact, she believed that there are no primitive people to whom death is not far more of a reality than it is to us. "We are beginning to act as if death were an unfortunate accident that need not occur." In general, she thought that all the peoples about whom anthropologists know anything have some relationship to the idea of continuity, either personal continuity in a return to earth or in the position of the soul, or continuity in the position of the family or the group. She believed this insistence on continuity, with different degrees of personal immortality, to be an essential of all known human groups.

but that will work Our present attitude toward antibiotics is not very different from the primitive's attitude toward a magical procedure

Anthropological Studies of American Culture

Dr. Oates, speaking from his experience as a chaplain in the Kentucky State Hospital, asked whether anthropologists would not consider it a good thing to come a little closer to home with their studies than working with the Balinese and other remote peoples In our own society, we find the idea of immortality not projected on a cosmic scheme of solidarity of the human race, but defined explicitly in relation to the solidarity of one's family or clan Isolation from this family or clan usually takes a distinctly religious form If community is not found in another group substituted for the family, the person breaks down and comes to the hospital Anthropological study of such people is desperately needed

Another vastly important area for anthropological research, Dr Oates continued, is study of the primitive forms of behavior—for instance, funeral practices—of the kinds of Negroes as well as whites who serve the tenant farmers of the deep South He wondered why it was not possible to get funds for such studies

One can easily get funds for such studies, Dr Mead answered The question is whether they would be conducted in a wide or a narrow comparative reference

This reminded Dr Mead of one of the Academy's projects that she had been watching—the training of chaplains for mental hospitals She had observed a tendency for career chaplains in mental hospitals to turn themselves into amateur anthropologists and to give up religion As an example, she spoke of a girl from a small special sect whose belief is that if a boy and girl want to marry, they both must have a confirmatory dream The girl has had the dream, but the boy has not, hence the girl breaks down A conscientious objector who has worked in a psychiatric hospital and has since become the local psychiatric authority decides that the

girl is psychotic and should he sent to a mental hospital. Without him, the elders of the church would have prayed over her and she would have recovered, probably reasonably fast. With the combined efforts of the elders and the chaplain—the self-styled psychiatric expert—after a few months the girl needs a mental hospital. The chaplain thinks it is his business to tell the hospital staff about the dreams, but he does not consider it his business to deal with the girl's religious problem.

Agreeing with Dr. Oates that more should be known about the local culture of the groups that come to the mental hospitals, Dr. Mead warned of the danger of the clergyman taking over the role of the social scientist and being unwilling to recognize that many persons who are psychotic are worried about a religious problem that has become deep enough to cause serious disturbance.

This is true, Dr. Oates said, with relation not only to anthropology, but also to psychiatry and psychotherapy. One reason is that in so many hospitals in some parts of the country there are no qualified psychiatrists. In these situations the chaplain who is not clear in his image of himself as a minister gets sucked into these vacuums again and again. Those concerned with the training of chaplains feel the serious need for carefully thought-out anthropological help to relieve the situation. Dr. Parsons suggested that some ministers are so uncertain about their religious roles that the situation Dr. Oates had mentioned seems to them to be an easy escape. They have a sense of being useful without really facing up to their own problems.

Dr. Klineberg said he thought that anthropology was being used at home rather more than Dr. Oates' comment indicated. As an example, he cited the recent full study of mental health among the Hutterites, which is an attempt to tie up the mental health problems of this group with the background of its culture. There is also a considerable amount of work on various Negro groups, though perhaps not the particular group Dr. Oates had mentioned.

Dr. Blizzard remarked that the study of the Hutterites was not one with which Protestant groups identified, as he understood it. Therefore, a problem of communication and of relevance to the concerns of this group exists. He thought that, from a scientific as well as a utilitarian point of view, a study of the culture of certain

religious sects or communities might well add to our knowledge of validation or verification as well as open up areas of application that now seem to be somewhat closed

One of the chief reasons why such work is not done, Dr Mead commented, is that social scientists do not want to touch religion If they are going to do it, they prefer to study shamans or statistics It has been observed that when an anthropologist studies a believing group that is different from his own, he has one set of problems They are sometimes manageable If he has labeled himself as unbelieving, in relation to the group being studied, the situation becomes almost impossible A unique study of family life in an Islamic community has been made by a woman anthropologist born in the Caucasus, herself a Moslem and able, with her objective training, to work with people whose values she could share [14]

The groups being discussed here find it very hard to get the right person to make the kind of study needed, Dr Mead said If a sophisticated Protestant, with good training in a seminary, is sent to study such a group, various group prejudices, in spite of his training and his belief in the correspondence of the doctrine of the group he is studying, will interfere with the scientific quality of the work On the other hand, anyone can go to the Eskimos and do a fine job The methodological problem, as indicated by Dr Oates, is very real

Dr Fremont-Smith asked how much training is available for a Negro anthropologist Dr Mead replied that the northern universities are glad to have them, but that by the time a Negro had received a Ph D at Columbia, he was less sympathetic with the people Dr Oates was talking about than anybody else would be Dr Fremont Smith then suggested that the problem is to find someone who would be a counterpart to the case of the Islamic woman anthropologist for the deep South Dr Mead felt that more could be accomplished if Negroes could be trained to study

[14] Eglar, Zekiye, *A Punjabi Village in Pakistan* New York, Columbia University Press, 1960 However, a vivid Christian sense can also illuminate studies of Moslem practice See the forthcoming book by Dorothy Van Ess, *Fatima and Her Sisters* to be published by John Day, and *Marriage Conditions in a Palestinian Village*, by Hilma Granqvist, 2 vols, Helsingfors 1931–35

Negroes; at the same time white persons should be trained to study problems of the white persons of the deep South.

Dr. Blizzard asked how a social scientist could be sure he had accurately understood the phenomena with which he was dealing, especially with such a subject as religion, where the scientist's personal involvement is so likely to color his perceptions. He thought a comparative approach would help. If a person who is committed to the religious group and who is qualified to study it, another person who has been "liberated" from it, and another who does not know anything about it, all studied the cultural or organizational aspects of the religion, perhaps real insight could be gained. There would be the possibility that the biases of the three persons might be cancelled out and some understanding of the phenomena beyond would be reached.

Accepting Dr. Blizzard's suggestion, Dr. Watson added that it was not really necessary that the person who has grown up in a limited and provincial culture become hostile and rejecting toward it when he has been emancipated from it. The hostility marks a halfway point in his development, a point at which too many stop. Cannot a capacity for empathy, an ability to see things through the eyes of one's informants, to share their feelings about life, be cultivated for the group in which the scientist has grown up as well as for the Eskimos or some other distant people? Dr. Mead replied that this cannot be accomplished if the social scientist or the teachers of the social scientist hold that some beliefs are right and some are wrong. Dr. Watson thought that a better way to train the teachers should be found.

The comparative study suggested by Dr. Blizzard is the method that anthropologists follow in working on a contemporary culture, Dr. Mead said. The research team always tries to have some members of the culture and members of others as well.[15]

An example of a good study of a religion and a culture, Father Ewing noted, was Tom O'Dea's study of the Mormons.[16] A pupil of Dr. Parsons', O'Dea had done so well that the Mormon book-

stores sold his book, which shows that he must have developed a certain amount of empathy with the Mormon people, as well as having done a good deal of tightrope walking Other studies of religions and of sociology and religion can be done by certain types of persons, Father Ewing believed A good teacher tries to ferret out the type of personality that is capable of doing such work

Chairman Klineberg expressed his belief that the statement that everybody has a religious point of view is somewhat incomplete, and said he hoped the afternoon's discussion would return to that point

A Religious Approach

Discussion Leader:
THE REV. D H SALMAN, O P , PH D

Discussant:
THE REV S W BLIZZARD, PH D

A Religious Approach

"When we ask how social and cultural factors affect religioo and mental health," Chairman Klineberg said, "we need to look at the question not only from the point of view of the social and cultural disciplines, but also from the point of view of religion As we agreed this morning, it is impossible to separate the three disciplines, because the same pheoomena, though they are in a sense integrated, cao he seeo from different directions " The fact that the discussion leader and the discussant for this session have had training and experience io the social scieoces—one in psychology and the other in sociology—in addition to their identification with the discipline of religioo, would certainly make the third sessioo a continuation of the two preceding discussions, though approached from somewhat different positions

Opening Remarks by Father Salman

Attempting a religious approach to the general subject of cultural differences insofar as they affect mental health seems to me to be practically impossible, because so little is known about the differences between religions from the point of view of psychology What kind of personality is typical of a given religion? What impact is made upon personality by a specific belief, or a practice or an organization of a church? I intend first to formulate a general conception of the problem as my theme, then to suggest certain variations on the theme that seem to follow from the general formulation and to suggest problems deserving further consideration

The notion of mental health implies, first of all, some form of adequate functioning of personality, smooth and easy operation of fundamental behavior mechanisms. It also includes the notion of adjustment to an environment—a specific environment—and successful adaptation to a total situation. Both the easy operation and the good adjustment, I believe, should be regarded as dynamic processes entailing growth and development.

The individual's adjustment may be considered at different levels, or as occurring in environments of varying amplitude and extension. The first thing a child has to do is to adapt to the family environment. When he goes to school and meets children of his own age, he is obliged to adapt to a broader social environment. Then he goes on to the wider environment of adult life: work and career, marriage and parenthood, politics and war. As the horizon broadens, the psychological environment grows more complex and more difficult to adapt to. Problems of growth and development arise spontaneously—problems of learning to adapt to progressively more involved and difficult situations, problems of maturity and achievement, of reaching success in some chosen form of human endeavor. And so the notion of adjustment broadens out to include not just a static personality structure that exists once and for all, but rather a dynamic striving that seems typical of human desire, a will to achieve, a longing for improvement, a need for perfection.

If this is so, some unavoidable dissatisfaction will appear from within, some longing for better things that is not easily satisfied. Indeed, if no such discontent occurs, there is no real striving for growth and development. One's achievements must always be below one's expectations. So the concept of mental health should not be based solely on adjustment or adaptation, but rather on an appropriate form of internal tension, on some inner dynamic urge to reach out and attain great and difficult aims. It should not call for mere relaxation by a reduction of needs and inner tensions, nor even for protection from outside stresses. The very notion of mental health should include a fundamental urge to grow and to develop and to achieve, a striving that contains its intrinsic gratifications (without them one would not strive), although the striv-

ing can never be completely satisfied and therefore produces a cer tain necessary amount of dissatisfaction and frustration It would seem to be around this central core of human personality that the trivial tensions of everyday life should be reintegrated so as to produce healthy individuals who are not adjusted only in the passive sense, but who are growing and developing as befits a living being

All this has been formulated without reference to religion, but I believe one more step is required Every human being must adjust to the wider environment of the total universe, as has been said in an earlier session He must consider 'his nature and his estate," as the old church language has it his condition within the whole and all the values involved He must face the problems of personal life and death, of suffering and bereavement, of sudden catastrophe and slow decay, of love and hate, of injustice and power, of good and evil All these and many more must be faced, for they cannot be consistently avoided Some account must be taken of all these ultimate values, and some adjustment must be made to the absolute that they reveal Meaning must be found for all these crucial facts of life and their implication concerning one's attitudes and behaviors must be recognized So a new and ultimate need arises within the personality—the need to adjust to the absolute, to strive toward what is appropriate and even required in this wider setting of one's existence, which differs, of course, in various times and places Here again mere reduction of tension is quite inadequate, for the fundamental longing, by its very nature, must remain unsatisfied In many cases, we should rather attempt to increase the essential striving toward ultimate values

The main problem, however, is integration, integrating one's life around some central and ultimate desire for the absolute as one conceives it, organizing one's personality in relation to some supreme value that includes permanent dissatisfaction but also some unique soul satisfying gratification that keeps one longing for it and oriented toward it

Some ultimate form of satisfaction is required here to make it possible to accept the unavoidable frustrations At this point, I think, lies a possible differentiation among cultures What form of satisfaction does the individual find in various organized cultural

religious settings: joy or detached acceptance, peaceful withdrawal or ecstatic delight, or what? The choice of this central value of one's personality integration is the first differential factor among religious groups, for the choice leads to specific types of personality and of integration. Here is a principle that needs to be spelled out, I suggest, taking into account the variations of the creativity that is central to the intrinsic frustrations and the mode of integration of the rest.

Cross-cultural Concepts of Mental Health

As Father Salman paused for discussion of the first part of his presentation, Dr. Fremont-Smith and Dr. Klineberg expressed warm admiration for the statement, particularly for Father Salman's inclusion in the concept of mental health the recognition that there must be discontent as well as potentialities for satisfaction.

Dr. Klineberg remarked that many of the persons concerned with the work of the Academy had been discussing the possible formulation of a concept of mental health that would hold for many different cultures. He wondered how the ideas of striving, tension, dissatisfaction, unsatisfied longing would work, for example, in Hinduism, which teaches its followers to get rid of striving and tension.

Father Salman noted that one of the examples of gratification he had mentioned was that of peaceful withdrawal, which would be the core of the Buddhist faith. The Buddhist monk works very hard—he starves himself, he begs, he is exposed to bad weather and cold and other discomforts; it is hard work. Dr. Klineberg said that, according to Father Salman's statement that the striving is part of mental health, one would have to say that the Buddhist mystic is mentally healthy as long as he is striving, but that he is no longer so when he has reached his goal. Father Salman replied that then he would have reached perfection, and the only man

who has done that, according to the teaching, is Buddha himself, later incarnations did not go as far as that, because they remained behind to save other men

Dr Allport took up Dr Kluneberg's point, saying that there must be at least relative cultural division "The Shintoist has a tripartite idea of nature and society, and he tries more or less to keep them in adjustment He does not have the sense of sticking out like a sore thumb, as we do in Western culture The ego is much more salient, and therefore more happy and more aspiring" Dr Allport changed the question to ask whether, according to this definition of religion, the Buddhists and the Shintoists and others are capable of as much religious consciousness as Father Salman had been talking about

Dr Blizzard intervened to say, first, that he, too, considered Father Salman's statement about mental health excellent because it included the dynamics of the situation But he wondered whether some other questions should not be raised before one could accept it as the religious approach He thought Dr Allport probably had this in mind Dr Blizzard had been asking himself what would happen if one tried to define mental health from the point of view of the individual's development, which he assumed to be Father Salman's frame of reference in his statement, and what if one tried to define it from the point of view of the culture, or the social structure and the operation of the social structure Following the line of reasoning set forth by Father Salman, from one tangent presumably one would have to ask what is within society, how does society maintain itself in a healthy fashion? Probably one would decide that the maintenance of society always requires a challenge to its existence, or a willingness to ask why that particular society continues to exist and what are the relevant questions about the health of individuals in relation to the functioning of this system Dr Blizzard thought the same kinds of questions would have to be asked in making a cultural analysis, particularly the question about whether or not there is a continuing conflict of values and an examination of values in relation to the culture being examined In that case, perhaps the responsibility was not to decide early in this discussion how the ultimate question was to be asked, but to

consider how persooalities develop in various cultures, and how personalities arc created in different types of societal organizations.

Father Salmao said be believed he had included something about these points in the second part of his presentation.

Tension and Choice of Values

Interpreting the inevitability of tensions as Father Salman's basic point, Dr. Klausner said that ascribing tension only to the frustration of striving seemed to him to apply only to achievement-oriented cultures. He felt that the point did not have to be tied to achievement orientation. Father Salman interposed to ask what achievement Dr. Klausner meant. Dr. Klausner answered that he meant the notion that there should even be achievemeot. Father Salman remarked that worldly achievement was not ultimate perfection. Dr. Klausner suggested puttiog the idea in terms of inevitable conflict deriving from the nature of any values, because value by definition involves choiec. In any problem of choiee, there is a negated side that is part of the individual and that will not be realized by the realization of the positive side of the value. Henee there is inherent an existential, inevitable tension in the realization of any value.

Father Salman said this was so in part because the value was absolute, and one must give up other things to make it absolute. "Because it was not really absolute," Dr. Klausner rejoined. "Because there is choiee, which means that you always have to take one side rather than the other. You cannot solve the choice problem by positing an ahsolute value, because if it is absolute, it is no longer a choiee."

Adaptation

"Biological thinking," interpolated Dr Parsons, "in the last generation or so has turned away from the passive concept of adaptation, as I see it, in the direction of emphasis on active mastery of the environment But we still use the concept of adaptation as if it implied passive adjustment to a given thing, which is not general"

Another consideration in the definition of mental health, Dr Fremont-Smith suggested, had to do with specifying in what respect a person was judged to be mentally healthy For example, if a person was well adjusted to the Nazi regime, or even striving to improve Nazism along Nazi lines, while another developed a severe neurosis because he could not conform to it, which one would be said to have the better mental health? Obviously we have no absolute criteria for mental health, but must ask "with respect to what?"

The final view, Father Salman said, is in relation to the absolute for the individual and cannot be discussed If one is a true Nazi, that is his ultimate value Why is the other man sick? Is it because of other values? Then one must choose between two types of values or two religions

Labeling the value absolute for the individual bothered Dr Blizzard He recalled the case of a German student friend of his who had come to this country to do his graduate work The young man had been well adjusted, apparently, to the society in which he had been reared He was active in politics, a member of Nazi youth groups He was a very religious person, the son of a professor of religion However, he never seemed to adjust to the type of religious values he found here, especially as they relate to political values He never adjusted to our society, in fact, he committed suicide He was always fighting the normal way of living in this country, was in endless conflicts with his associates He never had an opportunity to make any kind of reaction, to change himself in any respect To Dr Blizzard, it seemed that "when you post

the absolute of this, you have gone up a blind alley." Father Salman commented that the young man in question, being religious, would have had ultimate values distinct from those of all secularized societies, values that did not originate here and that would not allow him to adjust to secondary environments. The difference is important. The Buddhist monk may be perfect spiritually, but as an economic force he is weak. On the level of secular society, he may be judged as ineffective.

Dr. Klineberg summed up the group consensus as acceptance of Father Salman's statement that adaptation is not enough; one cannot define mental health as adaptation alone, even taking into account Dr. Parsons' remark about adaptation not being a static thing.

Adaptation for man includes aspiration, Dr. Wolff added. His highest integrative apparatus must include aspiration, or there is no adaptation.

Religious Striving in the Balinese Society

Dr. Allport asked Dr. Mead if she considered the Balinese as capable of intense religious striving as people in Western cultures. "They were not for a considerable period, because they had such a completely degenerative version of a great religion," she answered. "Nobody had done anything for about 400 years, so the striving was at a much lower level. There was only one man in the whole of Bali who believed it was possible to meditate and get greater truth. Everybody else was just told to go and ask him. This was a very low level of theological striving." In the last twenty years, Dr. Mead continued, during which Indonesia has become a secular state with freedom of religion, and the Balinese have been told that their Hinduism is nothing but a sect and not a religion, they have begun to work and religious striving is more active. But she was not willing to say, as had been suggested by others, that Easterners do not strive as much as Westerners because the end point they are looking for is Nirvana or reincarnation. She would

say of the Balinese that their society had had a static formulation and therefore did not call forth the same amount of aspiration in the past that it does now

Father Salman observed that he did not mean to say there was the same amount of striving everywhere, quite the contrary This is one of the big differences between people, similar differences occur within a single culture

Further Remarks by Father Salman

One of the problems now to be raised is integration There must be a central core of personality, the thing the individual wants, the ultimate value, which must be satisfying and at the same time have certain built-in frustrations

How much satisfaction is there in the life of an individual or a culture? What type of satisfaction will enable people to bear whatever is difficult in their lives and to accept or to integrate into their personalities the unavoidable frustrations? And how much frustration, and of what sort, will they be able to endure?

There are different types of joy or satisfaction the joy of contemplation for the happy few who can achieve it, ecstatic bliss for some, we are told, an occasional satisfying experience, the memory of which is effective enough to keep one going Then there is the satisfaction of duty faithfully fulfilled, of ceremonial observed, of moral behavior adequate to what one felt necessary, and social behavior adequate to what is believed to be good On a still lower level, there is mere relief from tension, removal of anxiety, escape from danger, recovery from sickness, avoidance of death There is satisfaction in peaceful security, in the feeling that if one accepts what is right and does what is required of him, everything will be all right Fervent faith, lived actively, brings a different type of feeling—hopeful trust in the future

On the other hand, there are fundamental feelings that will give this absolute value and thus form the core of one's religion but that are intrinsically not satisfying We can follow Riesman's classi-

fication [1] here: traditionally directed religion, in which tradition creates an obligation that is not completely accepted and is experienced as a burden; or the inner-directed religion that has remained on the level of a superego, not integrated, not accepted, but regarded as a painful, punishing work rather than a rewarding one; and outer-directed religion that requires conformance to social pressures, though they may not correspond to inner feelings.

In the cases where a rather painful aspect of religion dominates, there is, of course, a great weakness. Not only is the person unable to integrate normal life into such a religion; it is intrinsically disruptive of the personality because it is given ultimate value when it is not really fulfilling the function of such a value. The problem of integration is more extreme in this case because it involves the personality as a whole in relation to the absolute values one has chosen.

The second problem is that of the type of experience that one looks for. Few people spend their lives concentrating on religion or ultimate realities. Our lives are usually profane to a considerable degree, with a small effort at religion from time to time. In more primitive cultures, almost everything is more or less religious. Much of it is general, everyday, familiar, and unexciting. Hence people seek some form of more intense religion, some kind of experience that can rekindle their convictions and intensify their beliefs. This is the problem of giving due importance to values one knows about but does not effectively use as one feels one should. There are many forms of this kind of experience, conditioned, of course, by the society and the local organization: ecstatic dancing, initiation ceremonies, bloody sacrifices, or the milder, more modern forms of pilgrimages, or a prayer meeting on the campus, or revivals, or sacraments, or ordinary public worship. There are private forms, also: the dream of the guardian spirit like the vision of the Plains Indian mentioned in the earlier session; enlightenment through meditation; experience of the presence of God in contemplation. All this is organized socially. Each culture channels these efforts in a specific direction. It is important

[1] Riesman, David, *The Lonely Crowd.* New Haven, Yale University Press, 1950.

to know what is attempted in this field and what effect it may have on the individual Two examples of such experiences are found in the Western world hysterical phenomena of various types, which have played a large part at times in the history of the Christian Church, though nowadays they seem to have disappeared, not being accepted as legitimate forms of religion, and the type of experience that seeks the conviction of being individually saved, of atonement and the action of our Lord Jesus Christ being effective in the saving of the individual I consider this latter a difficult thing to achieve and to keep afterwards, it therefore raises great stresses within individuals every time they try to achieve it

A third problem is the amount of personal support one may get in one's religion, which is also organized by the social setting—the amount of help one will find when one has personal problems This depends upon the existence of recognized specialists whom it is a custom to consult In many primitive religions there are the medicine men, the shamans, the witch doctors, the interpreters of dreams, and so forth The ministrations of these people may be intensely therapeutic or educational The same kind of thing is a fundamental institution in many higher religions One cannot imagine the religions of India without the guru, the master, who is consulted as the special authority, or Moslem spirituality without the sheik, or Russian orthodoxy without the staretz, and so on through many forms of spiritual advisers and confessors With these consultants, there is far more support for the individual than without them

There are problems attendant upon these relationships The masters often wield immense authority as personal representatives of God The relation between master and disciple raises still other problems, depending upon the dynamics of the interpersonal relations, many of them culturally determined but also depending upon the individual I think there should be study of the problems of the cultural couple, not only of the fundamental couples such as child and mother, husband and wife, but of master and disciple in the case of religion and in scientific research and artistic work What is healthy in this relationship? A specifically contemporary problem arises here I wonder how much modern education gives to the prospective disciple of a master in spirituality, how much

understanding of how to accept such a master easily and gracefully and usefully in a healthy way, with neither infantile dependence nor aggressive revolt. The notion, prevalent today, of "you are no better than I am," seems to me even more disturbing than the earlier formulation, "I am as good as you are." In the latter, at least there is some indication that "I hope to be as good as you are." The incapacity for respect, for deference, for reverence would seem to be fatal not only to a healthy relationship with a master, but to a truly religious attitude, an affective attitude toward the absolute God.

In contrast to this personal contact with a spiritual leader there is mere collective worship, the present unchurched masses of the nominally faithful who have no contact with their leaders, the outsized parishes, the populations out of touch with an adequate clergy, or the congregations that have an active social and charitable life but little spiritual direction.

In all these cases, the individual's deepest problems remain untouched, undiscovered, unsolved. Because a person's fundamental values and, therefore, his main force of integration are involved, I believe that such situations bear grave danger to mental balance and health.

Mental Health with Respect to Values

Dr. Kolb commented that, as he understood Father Salman to have described some of the empirical and natural problems that every society has to deal with, he had been talking from a certain conception of human personality containing elements of striving, discontent, dynamism, frustration, and so on, and that he had then defined mental health as solving these problems. This conception, Dr. Kolb thought, was based upon certain notions about the nature of man that are ultimately religious in nature, although in a somewhat truncated sense. A Hindu, for example, would conceptualize and state the problem entirely differently. If one extended somewhat the rather incomplete, existential image of man presented by Father Salman, one would move either in the direc-

tion of the conception of man involved in the writings of Albert Camus or in the direction of the conception of man adopted by some of the Christian existentialists In other words, the statement of the nature of the basic problem that religion is conceived to answer is a religious conception and, therefore, the statement of the problem dictates the answer

If this were true, Dr Kolb continued, the next question (and it would apply to Nazism or to Herberg's definition of the American religion or to anything of the sort) would be what ultimate values are such people committed to, and what is the relation of these values to mental health? At the theological level, Dr Kolb thought, there is the question of idolatry, and at the mental health level the question is whether orientation to some particular value system may not be actually dysfunctional for mental health even to the point of creating a culture that cannot survive for more than a generation The Nazis, for example, may be as deeply committed as another group, but there is a type of commitment that is bound to have dysfunctional coasequences The result of this train of thought, as Dr Kolb saw it, would be that one was caught in a kind of unavoidable relativism, that one started with a conception that would set up certain criteria by which certain types of ultimate commitment and certain solutions for the problems would result in lack of mental health as we conceive it

Father Salman thought this was not immediately necessary He had intended to continue by taking up the ultimate attitudes toward the universe Among them he would have mentioned withdrawal, seeking peace, quiet acceptance of various types, active involvement, or a mixture of all these, including complex cultures, which allow for a variety of ideal vocations For example, in the Brahmanist culture the boy is first trained by a master Then he marries and raises a family Then he leaves the world to go into the forest and meditate This is an individual matter, other cultures have a plurality of possibilities The Buddhist monasteries are big institutions, with thousands of people in them But people can do other things besides enter a monastery Giving alms to monks, for instance, is one way of preparing for the other life Many people have some form of religion, of a second rate nature, that prepares them comfortably for the next world

To Dr Kolb's remark that, with the image of man used in his

statement, one would ultimately have to conclude that the Buddhist lacks mental health, Father Salman replied that he did not so conclude. "The primitive Buddhist tries to purify his soul. Then he tries to go away from evil of the moral type, then from evil thoughts and desires, from all desires; insofar as he integrates it, he is striving to attain the ultimate value of purity of soul." Father Salman noted that he had not said whether such a system was good or bad. Dr. Kolb added that he saw one element, one criterion of mental health, implicit in Father Salman's conception of personality: the idea that the truly mentally healthy commitment is one that leaves the individual still grappling with the world rather than escaping from it. Father Salman called attention to his consideration of deliberate withdrawal from the world, the total uninvolvement of Buddhism, or the going into the desert of early Christianity as possible forms of ultimate value.

Dr. Blizzard asked whether there was not a difference between a logical necessity of the kind of thing Dr. Kolb was talking about and the possibility of its existence. Father Salman seemed to be saying that the conclusion Dr. Kolb reached was a possibility, but not a necessity.

"What criteria do you use," Dr. Kolb asked Father Salman, "to judge the person with an ultimate commitment to blood, soil, and race as mentally unhealthy and the one with ultimate commitment to withdrawal as falling within the range of mental health?"

Father Salman replied that he had not made such a judgment, because there were two possibilities of judgment: mental health in relation to the culture or to the ultimate value. The choice between the ultimate values is purely a religious one.

Faith

Speaking of religion in relation to mental health, Rabbi Hollander observed that it is important to stress that the element of faith provides the means that enables the clergy to help people achieve their basic aspirations. There are those who may feel that

they can achieve ultimate goals through other means The religionist, however, holds that only through religion can one attain the greatest fulfillmeot

Dr Mead asked whether this goes back to the religionist saying, 'This is the only way you can attain meotal health," which is not the same point as the relation of meotal health to religious striving As for Nazism, ooe can now look back with the perspective of history and say that it is quite possible that for a group of people who have known a more universal value to turn their backs on it has consequenees for their ability to accomplish their purposes This is not a religious judgment of how people handle their values, but a naturalistic ooe

Two quite different problems were involved here, Dr Klineberg said There is the religious value, or faith, but the other question is, which religion? Some of the points made about Buddhism for example, as compared with the Judaeo-Christian point of view, brought another dimension into the situation The question is not just religion versus naturalism, since not all religions would agree in this approach to the 'natural"

A discrimination of levels might help, Dr Parsons suggested It would introduce two different orders of relativity and might avoid the dilemma of completely general criteria versus completely relative criteria

Commitments

Agreeing with Father Salman rather than with Dr Kolb on the matter of the striving in Oriental religions Dr Parsons called attention to the distinetion between the kind of frustration and disorganizatioo that people experience when their fundamental commitments are unelear, on the ooe hand, and on the other, their incapaeity to earry out their fuodamental eommitments whatever they may be, in a broad sense This incapacity includ-s not only implementation, but aeceptanee of whatever disappointment and frustration is part of the total pattern of their commitments. Dr

Parsons believed that science has more to say about capacities than about the bases on which people make their fundamental commitments, but that there is a connecting relativity in the fact that these commitments are not purely individual; they are institutionalized in cultures and societies and they vary from culture to culture and from subculture to subculture. Therefore, the kinds of problems people meet, from the point of view of capacity to face their commitments, will vary. To this degree, the problem of mental health is culturally variable, because it will not be the same for people differently placed with relation to various commitments. Hence the concrete steps toward mental adequacy are likely to vary in ways about which we are beginning to know something, though there is still much to be learned.

Dr. Parsons thought that a far greater body of scientific knowledge about human motivation and personality could be attained and brought to bear upon these problems, with appropriate adaptations to the kinds of differences that exist. And the social scientist —the anthropologist, the historian, and the sociologist—could tell us a great deal about the empirical nature of the ranges of these variabilities and how they structure the situations in which different categories of people are placed and, therefore, the kinds of strains to which people are exposed. He believed that the problem involved a graduated series of relativities rather than one area where everything is relative and another where nothing is relative.

"I should have said all that if I had been able to," Father Salman remarked. "The amount of mortification, of celibacy, of solitary life that people are able to carry on in certain social conditions, while maintaining a certain level of personality and integration, are empirical matters that can be studied."

Striving versus Tension

A distinction should be made, Father Mailloux thought, between *striving* and *tension*, as we are reminded of it by many who have been coping with this problem, however different their viewpoint

may be Freud says that death is the goal of all life Each organism establishes its own circuitous path to reach this end Tension arises whenever this circuitous path is disturbed However, Freud never implied that mental health is the absence of suffering To one of his patients, he said bluntly "If I cure your illness, this only means that I will help you to get rid of your symptoms, but you will still remain with this suffering that is the common lot of humanity!" Father Mailloux recalled that Dr Allport, in his book entitled *Becoming*,[2] stresses the same point, though approaching it from an entirely different angle—the strenuous striving toward a goal that is a never-attained achievement rather than the tranquility of death This evidently applies to a man who has a religious attitude toward life, he may display constant striving without disrupting tension Denis de Rougemont makes the same point in his book *Love in the Western World*[3] Studying the problem of love and death, he observes that love, as a passion, appears constantly as a disrupting element, if it were completely satisfied, it would be connected with death To remove the immediate danger of death, the same unconsciously inhibitive process constantly comes to the fore under the form of re emerging tensions, as abundantly shown in the story of Tristan and Isolde Such tensions always provide new situations, permitting them to keep alive a passionate love that will never be satisfied

Dr Watson thought that at two points Father Salman's presentation had challenged some rather widespread implicit assumptions of psychotherapists in the mental hygiene field In the need to revivify the religious experience, he seemed to find justification for a Dionysian existence, whereas most workers in mental hygiene have been rather Appollonian, to use Ruth Benedict's term, that is, they have believed that one should live near a golden mean without all the ecstasies, the ups and downs Perhaps this should be questioned in the light of this analysis of the striving for revivification and experience

The other point, Dr Watson continued, concerned independ-

[2] Allport, Gordon W, *Becoming Basic Considerations for a Psychology of Personality* New Haven Yale University Press 1955

[3] de Rougemont, Denis *Love in the Western World* Translated by Montgomery Belgion, New York, Pantheon Books, 1956

ence, which has come to be highly valued. Many people say that when a wise person gets into religious difficulties, he goes to somebody else, to an expert who has spent his life dealing with these things; he does not consider himself competent to work out the problems for himself. Perhaps there is a kind of corrective influence flowing from this religious analysis to the mores of mental hygiene.

Father Salman replied, concerning the first point, that he had been describing what people actually do in various religions. They try to reactivate their religious feelings because they feel that religion is important, but their interest is not strong enough to integrate their lives. It is not necessary, of course, to go into ecstasies; one may not be very successful at it; the types who always succeed are not very good.

As for the second point, Father Salman noted that he had mentioned the sophistication of the specialist consulted in many religions, which is important in the modern world. We have developed far more personal attitudes in all things, more personal religion, more personalized relations with our God, growing out of the sociological religion taught by parents and school into something more mature. But even on that level we remain human, and therefore social. It seems to be a part of mental health not to invent one's own religion, a religion not shared with anyone else. Any member of a church would appreciate the necessity for membership in a social setting of some sort.

Phenomena of Integration

"Some years ago," remarked Dr. Wolff, "stimulated by studies initiated by communist methods of indoctrination and interrogation, I tried to design a number of experiments to study some of the phenomena in the highest level of integrated functions of man. It became apparent that man's nervous system is so put together that when he is not in an adequate or continuous state of interaction with his environment, his brain fails; this state is usually re-

versible, but it may not be In other words, the price he pays for being what he is structurally and functionally is that he has to be in some state of interaction, excitation, or stimulation Nature abhors a vacuum and man abhors boredom He is constantly nibbling away at the edges of his state of tranquillity and security to engender a relationship with his environment that keeps this apparatus going

"We have been able to show," Dr Wolff said, "that a high frustration tolerance and a capacity to recover from failure are among the special capacities that man's nervous system brings to him Some people have more of these capacities, others have less During his most vigorous periods, man has the most that he ever has, when his brain is damaged by injury, infection, or attrition, he has less In his optimal state, he abandons security for the sake of aspiration

"Substituting the words 'health in general' for 'mental health,' we can see from an investigation of a large group of people whom we have studied for several years, that illness is an entity cutting right across the board, that those who are most frequently ill are ill as regards their mental state, their medical state, their surgical state—every kind of state that physicians have to do with For the sake of our concerns here, we could leave it at mental health, but it does not stop here Man's health is disrupted during periods of nonadaptation This involves certain feelings of which anxiety would be one But anxiety may not be conspicuous A person may have bodily adjustments that are inappropriate to the situation and that ultimately damage the organs, disease follows

"René Dubos carried this a step further in his monograph *Mirage of Health* [4] He pointed out that man, put together as he is, on the one hand is capable of elaborating a mirage of health, and on the other hand is constantly destroying the possibility of achieving it He pursues something that may bring health, but that often enough does not, instead it frequently brings sickness and sometimes death

"Are we not," Dr Wolff asked, "too much taken up in this dis-

[4] Dubos, René Jules *Mirage of Health Utopias Progress and Biological Change* London, George Allen and Unwin, Ltd, 1959

cussion with the issue of mental health? Is health the end of man? Is comfort the goal of his existence? Is survival necessarily the greatest good? I feel that our concerns ought to be with finding out the methods or formulations in religion that would allow the greatest development of man and less with the mental health of the particular individual."

Concepts of Mental Health

Dr. Klineberg spoke of two points made by Dr. Marie Jahoda in her book, *Current Concepts of Positive Mental Health.*[5] The first was that she had given up the hope of formulating a single definition of positive mental health. From the literature on the subject, she had noted six major approaches to defining mental health. Some of them are distinctly culture-bound, while others are much less so. An example of a culture-bound concept of mental health is the one in which a criterion is the ability to stand on one's own feet, to be independent, not to ask other people what to do. There are probably never any persons who are completely independent, but certainly there are varying degrees of independence encouraged by the culture or held out as values by some cultures—notably ours. In other cultures, such as the family structure of ancient China, the individual is not supposed to be independent, but to be a member of the group, and to act as such.

Another concept of mental health mentioned by such writers as Erich Fromm, Gardner Murphy, and others, defines it as a process of growth, as maturation, development, moving on to ever-new accomplishments or aspects of life. This one would apply to many, if not all, cultures rather better than the notion of individual independence.

Still another, with which Dr. Allport is identified, is the notion of integration, of a kind of unity of the personality, without too

many inconsistencies or incongruities, an integration often brought about by a religious orientation or by a relationship of the individual to the universe in general This, too, might be regarded as cross-cultural

Dr Klineberg suggested, therefore, a compromise position that one should think of mental health as having many different aspects and give up the hope of finding one statement about it that would satisfy all the specialists, that one should see it as a balance between a number of aspects of personal development all of which need an optimal degree of development in order to produce a completely mentally healthy person Perhaps we should even give up any notion of complete mental health

Looking at the question this way, Dr Klineberg thought there might be agreement that some concepts of mental health do apply in all cultures and in all great religions Others do not, or at least not to the same extent, they show the need of varying degrees of modifiability from culture to culture

Another element in a concept of mental health, Dr Klausner observed, is the notion that a mentally healthy person is one who can act in the face of anxiety He thought that Dr Watson's earlier mention of Dionysian elements suggested a kind of hedonism Before that, the notion of basic tensions had been stressed Dr Klausner wondered whether the answer to the problem would not be a mechanism to enable people to act despite tensions and anxieties To this mechanism he had given the name of "faith"

Model for Attaining Faith

The next question Dr Klausner had asked himself was how do people get faith? To study it, he had constructed a four step model for the achievement of faith that he believed was cross-cultural and cross institutional in its most general form That is, he thought it was possible to make a model for the achievement of faith independent of the values to be implemented, so that there would be functionally alternative ways of getting faith Religion is one way

Families have a faith-achieving function; psychotherapeutic groups another. The differences between religion and psychotherapy aside, they both have a faith-stimulating function, developing in the participants the ability to implement the values of the culture or institution.

Dr. Klausner proposed four general steps for attaining faith through a process he called social de-differentiation—the symbolic elimination of certain kinds of differences among men. He was not speaking of a social faith. There is an individual religion, too, he thought, of which the social is an aspect.

The first step is the decision as to who gets into the faith-achieving group. "This is the card of entry, the fact that we all belong to the same religious group. It permits us to participate in the ceremonies. There must be some kind of symbolic way of legitimatizing the participation of one with another in the faith-achieving ritual or ceremony."

The second step is the stage emphasizing the commonality among the various participants, the particularistic relationships among the people. This is the notion of the tribe or the people coming together on Sunday morning for the congregational aspects of the ritual. The belief system has a function at this stage, too, Dr. Klausner believed. The assertion of the acceptance of a certain doctrine brings people together intellectually. Many other things have a part in religious faith-achieving, in family and psychotherapeutic systems with this kind of function at this stage, such as praying together. It is no accident, Dr. Klausner noted, that so much prayer is in poetic form; it helps get people into a harmonious kind of movement.

The third step is that of emotional release—a sort of cathectic stage. Here such things as rhythm and music play a part in faith-achieving, whether the large rhythms of the festivals occurring during the year or the smaller rhythms of chanting and prayer.

The final stage is one in which the emotion that has been released is not allowed to become diffuse and spent, for that would be simply orgiastic, but is assembled and channeled from the values to the acts by which the values are to be implemented by that specific faith-achieving group.

"Depending upon the type of act or the type of value," Dr Klausner continued, "there would be different content within this general model For example, if the thing to be enacted is a group of warriors going to fight a war, the war dance is appropriate The relation between the content and the final act is a metaphorical thing in which the steps often tend to be symbolically imitative of the act

"The act need not be in the external world With the Oriental religions, as has been pointed out, there is withdrawal, which I understand to mean something quite as active as fighting a war, except that the object of active control is internal rather than external, it is a matter of endurance rather than courage There are characteristic imitative ways in faith-achieving that lead to the need to endure, such as the Indian passive resistance, for which the preparation is meditation rather than a frenzied warlike process I think the correlation between the form of the act—frenzy or meditation—and the thing to which it leads—war or endurance—can be shown in a number of situations"

Dr Watson, who considered the four step model described by Dr Klausner a stimulating picture of the way in which a good many institutional faith building processes operate, asked how it could apply to a case he had in mind a graduate student whom he had been trying to help, a young man who had lost all faith in himself, in his ability or the possibility of his ever doing anything Dr Watson could not see how he could use any of the steps outlined to help the student find confidence and courage as a solid emotional basis for life He asked whether the faith achieving model could be translated into the dyadic relationship of the therapist and a completely disheartened person Father Salman added another relationship, that between the individual and God, which also is dyadic "Wouldn't your term be, not 'faith,' but 'hope'?" Dr Klausner replied, "It has elements of hope in it"

Father Salman recalled what he had said before about gratification as motivation, meaning, of course, not sense pleasures, but spiritual gratification, a minor form being relief from a feeling of insecurity and a higher form of joy "Nirvana in the positive sense is meant to be joy, I think, finally, when one disappears into the

absolute." He believed that people find some satisfaction in doing even the things they do not like to do; otherwise they would not do them. Dr. Klausner considered this explanation teleological. He suggested that Father Salman was saying that the martyr was able to ascend the pile of faggots because of his hope of ultimate salvation. But this would not explain how he could endure the pain of the flames on his flesh before the situations were realized. Dr. Mead objected to the introduction of outworn teleological notions here; she saw it as an ordinary feedback mechanism. "The image of the thing we are going to do can be built into the act. This does not throw the model out."

"But there is some present gratification, too," Father Salman observed. "A man works for his wife and children. The work is hard, but he is doing it for somebody. The money has not been paid to him yet, but he is satisfied now, thinking of it."

Mental Health Paradoxes

Dr. Meserve, prompted by Dr. Klineberg's quotations from Dr. Jahoda, had been noting various qualities mentioned during the discussion as contributing in some way to mental health. The result, he said, was a series of paradoxes: independence is desirable, but it must be tempered by a sense of obligation to society; growth is necessary, but some sense of foundation, of roots, must be kept; one must go forth through life, but must also know how to withdraw from life, to alternate between worldly and spiritual life; one must be integrated, but too much integration destroys the creative spark; one must be an individual, but he must learn to adapt; faith is necessary, but there must be doubt, for without it faith can never grow beyond a fixed point. All these things, he said, seemed to balance on a knife edge that was mental health. The question that followed was this: "Was Jesus mentally healthy? Was Saint Paul? Was any one of the great creative people in history mentally healthy, in the context of some of the things we have been saying?

They had some rough edges, and I want to keep room in our definition for these rough edges"

Addressing himself only to the paradoxes, Dr Klineberg said it seemed to him that the point was that, for all these virtues or values regarded as related to mental health, one should never go to extremes This, of course, was hedging, saying that we need a satisfactory amount of personal independence, of integration, and so on Dr Jahoda has pointed that out, saying that it is the optimum and not the maximum of the traits she mentions that is the criterion for mental health It is most difficult to define the optimum Finding the proper balance is one way of putting the matter, which is different from stating it as a series of paradoxes

"But each one of these qualities has an opposite, a certain amount of which is also necessary," remarked Dr Meserve Dr Klineberg agreed, but noted that in previous discussions of mental health it had been thought of as a sort of range from one extreme to the other In some cultures one would be closer to one extreme, and in other cultures closer to the other extreme Dr Meserve added, "And at different moments in your life you might be at different points in that range" "With the capacity to alternate between the two, otherwise there will be a dangerous rigidity," said Father Salman Dr Parsons called this a general property of complex systems, a very important consideration

Father Bier observed that this notion of paradox was a central one in the religious life The Gospels talk about the paradox of losing one's life to save it, a principle that runs all through the Judaeo-Christian tradition In a more limited way, perhaps, one of the fundamental concepts of virtue is that it is a mean between two extremes The same kind of concept appears in the psychological order, in mental health terms

Accepting the idea of the paradoxes, Dr Blizzard expressed doubt that finding the optimum within the range of possibilities was necessarily the resolution of the paradox as far as the individual is concerned He suggested that the solution might lie in whether or not the individual, wherever he might be in the various continua, could find a meaning in the choices available to him The individual is likely to give up in a crisis when he cannot see that

his state is in aoy way related to the possibility of cootinuity and to meaning in his existeoce. When he cannot find meaning in an experience, he is in a rather unhealthy state.

Father Salman remarked that the individual makes his own perfection, whieb is his alone, and therefore allows for choice within the range. The point about balance seemed to him of great importance. He referred to Dr. Allport's book about the individual and his religion,[6] in which a type of mature individual balance, in a sense of relativity, of humor, and various other thiogs, is indicated. But the idea of balance would not fit all great religious leaders, who were extreme men in some ways. Sueh men as Saint Paul and Mohammed, Father Salman thought, would be considered mentally healthy only in relation to certain esseotial elemeots. There are supreme values in giving up one's whole life to religion, but on the way there are aceidents and difficulties. Saint Paul, as he wrote, had many troubles, as did most of the other great leaders, no doubt. They were not cultivated, tolerant, sophisticated persons, moderate in all things, akin to the modern ideal of the gentleman and scholar. That type actually does not correspond to the notion of the genius in religion, Father Salman said.

Dr. Meserve noted that he meant to say that religion comes upoo the sceoe and preaches that one should not be of this world; one either should be withdrawn, free from any kind of desire, or should be the creative type, in the religious sense. Father Salman agreed, adding that the individual must always do his best. The Buddhists, all Hindus, give one a chance to be reincarnated. Perfection is the end to be sought, but not to be achieved, at least not immediately.

Mr. Wolfson asked, "When does tbe relationship of meotal health and happiness come into play?" Father Salman replied that he had called joy the central virtue. Joy has to do with hope, and "this, I think, is the purest type." Happiness is indication of good functioning. "I don't think we can look for it immediately, because any type we try to achieve within the range of immediate possibilities is not adequate. The moment we have it, it no longer satisfies. We must seek higher and further along."

[6] Allport, Gordon W., *The Individual and His Religion*. New York, The Macmillan Co., 1950.

Mental Health and Creativity

"The problem may have to be solved by taking two entirely different value continua," Dr Allport said "We could define mental health with difficulty along the lines we have been talking about, but I don't think you can include creativity It seems to me that the religious fanatic may be extremely desirable on the scale of creativity, but he may not be mentally healthy In other words, I think we are trying to put too much under mental health Creativity is a positive value, too I am all for crackpots and fanatics, but not because they are mentally healthy"

Father Bier cited a recently published book, *Heroic Sanctity and Insanity*, by Father Thomas Verner Moore,[7] as dealing with a question now of great interest in Catholic circles the mental health of saints Father Moore says unequivocally that he is discussing the question of the extent to which a very special kind of sanctity is compatible with the ordinary notions of mental health and sanity He maintains, much as Dr Allport had just said, that there are other values that more than compensate for a little less of what is called adjustment or mental health

There are different kinds of creativity, Dr Parsons noted For example, a creative mathematician is not the same as a creative diagnostician in medicine There is also the matter of the effect of the situations in which the creative person works upon the reception given to his message or product For example, the French medical profession of the late nineteenth century received Pasteur with bitter opposition, on the other hand, Einstein was greeted as a genius almost immediately upon the publication of his first important papers These facts should not lead to the inference that Einstein was not creative and that Pasteur was There are several different independent variables But the heroic qualities are usually important where the situation is such as to generate formidable

[7] Moore, Thomas Verner, *Heroic Sanctity and Insanity* New York, Grune and Stratton, 1959

opposition. It may be, however, that unheroic people are extremely creative, making contributions of the most fundamental sort in the other type of situation. They are never faced with the question of whether or not they are heroic in the sense of motivation to martyrdom.

This is a different concept of the heroic, Father Bier commented. Father Moore uses the term in a somewhat more restricted sense. In canonizing a saint, the Catholic Church must establish the heroic nature of his virtues, not necessarily in terms of martyrdom, but from the standpoint of the arduous. The saint has practiced virtues to this arduous degree. That is the sense in which the heroic is thought of in consideration of sainthood. Father Moore maintains that this kind of practice of religion, not just a nominal adherence to religion, is a positive contribution to mental health, that there is a parallel between the heroic practice of religion and positive mental health.

Early Development of Ability to Hope

Turning back to Dr. Klausner's model for faith-building, Dr. Mead said that probably the simplest cross-cultural model that is relevant to mental health and religion is the establishment of the ability to hope, to have faith, within the first two years of life. There is no evidence so far that there are important exceptions to this. While there are different forms of successful mothering, unless the child establishes a strong relationship to human beings in his first two years, he may suffer irreparable damage. The profoundly depressed person, such as the graduate student about whom Dr. Watson had spoken, whom no one can help later in life, is the one who has not established this ability to hope. Therefore, the model for faith-building ought to include the condition that the society has institutional conditions of such a nature that the infant can establish this capacity for faith. One cross-cultural dimension would be conditions for all infants, so far as they can be managed, that would include such things as not having orphan

asylums, which are destructive With the necessary ingredient of hope, the child can participate in a religious system that is en nobled and activated by acts of heroic sainthood The hope will he necessary for the individual whose life can be enriched by the saint as well as for the saint

Asked by Dr Klineberg whether she felt sure that the basic hope or trust must be developed by the age of two Dr Mead replied that the only indication that it can be replaced later in life is a study made by UNESCO in Paris With 600 hours of the most gifted psychiatric treatment, it may be possible to bring a child to a semblance of what he might have been, that is the best that can be done There is no evidence yet that basic, extreme damage done before the age of two can be repaired Some societies are undoubt- edly so arranged that hope waxes as one grows older Others are arranged so that a maximum of hope is established at one year, and then it can wane steadily and the individual can survive in that society

Dr Klausner regarded the requirement of this early establish- ment of faith as applying to the general problem within families There must be the cathexis, the 'togetherness" stage There must also be opportunity for an effective release within the family, so that tensions do not build up to a destructive degree The father should give some discipline, too, so as to direct the performance of functions

Some semantic differences in the use of the word 'faith" ap peared at this point in the discussion Dr Klausner noted that he had used it not in the sense of belief in a religious principle, but rather as synonymous with confidence, as including a kind of hope Sociologists and other social scientists accepted this meaning readily enough, religionists found it somewhat confusing

Dr Oates introduced the Kierkegaardian conception that it is at the level of faith that we move out of the aesthetic stage of willing everything into the ethical and finally the religious stage of willing one thing

"I have been a little apprehensive here," Dr Oates continued "lest we assume that we are not going to have to make any de cision about what Father Salman called the absolute The word got lost somehow in our discussion When we come to decide what is

the absolute for us, we do this as an act of faith, do we not?" Father Salman agreed.

Communication of Faith

Referring to Dr. Wolff's statement about mental health as not an ultimate but rather an approximate value, Dr. Oates thought that "unless we have some clear and articulate way of transmitting faith, when we come to the patient on the back ward, for whose mental health all that can be done has been done and all has failed, we have no way, apart from some ultimate faith, to communicate any hope at all to him. Here is where the unique role of the minister comes in. As Dr. Mead pointed out, the chaplain is not there to function as an anthropologist. But he is there to find some meaning with a patient, even in the presence of a total collapse."

In answer to Dr. Wolff's question whether that faith can be communicated to the patient, Dr. Oates said that it can be, "in the only possible way: being a witness to the truth you believe."

Dr. Kolb asked whether it makes any difference what the object of the faith is. Dr. Oates replied that it would make a great deal of difference. Speaking as a theologian, he said that the character of God is qualitatively different, as He is described in the Old and New Testaments, from the polytheistic manifestations—the fertility gods and deified desire gods. This is what we mean when we say there is one God. "We as Christians say that we have come to terms with the fact that there is a qualitative and essential difference between the Lord Jesus Christ and other manifestations of religion."

Dr Oates replied that there would be some differenee in his own attitude toward the patient, which might have a secondary value for the patient "Do I give up hope for him myself, and is my relationship to bim so devoid of a card of entry that there is no hope in me for him?"

What speeifieally would be the differenee in the chaplain's attitude, Dr Wolff wanted to know Would he be more willing to sit and talk with the patient even though there was no response, just beeause he felt that something could be aceomplished? Is this what Dr Oates meant by the effect upon the chaplain? Dr Oates answered that he had seen just that happen—he had seen such an effect upon the chaplain and possibly upon the patient Dr Wolff asked Dr Oates to describe the behavior change that he would use as an indieation of the effeet

Dr Oates said that in a clinical record kept by a pastor there was a description of a patient whom he bad visited regularly over a period of weeks and months, even though he had very little verbal communieation with him Ultimately he made eontaet with the patient Dr Oates did not believe the pastor would have continued his visits unless he had had some sense that he was doing something meaningful for the patient

Rabbi Hollander reinforced what Dr Oates had said by remarking that faith is often the only resource to whieh the patient in the back ward ean respond This is also true with regard to people in the eommunity It is the element of faith and trust that underlies and strengthens the elergy's ability to help tbe average person in his quest for a state of mental health For example, when a clergyman attempts to give premarital counseling to a young couple in a series of eight or ten visits trying to indicate certain broad religious principles that will help them establish a mentally healthy relationship they will understand and profit from what he is trying to say only if they have a certain faith in tbe principles he is talking about "In other words, thcy will have to make a certain commitment of faith " The principles in and of themselves will he ineffectual unless the individual views them as being based on eternal verities

Relating Dr Oates' statement to scholastic terms, Dr Hofmann suggested that the distinction between *fides* and *fiducia* might apply *Fides* to Dr Hofmann meant the content of faith, an articu-

lated faith not directly related to the whole term of mental health and not directly communicable. In *fiducia* would be included hope and faith and other terms used in the discussion. He thought a good research project might be a psychological study of the bearing of the important aspects of the young person's formulated faith developed in his early life upon the crisis situation wherein he comes to doubt and is challenged and stimulated by representatives of a faith, and then upon the final achievement of a *fides,* an articulated faith that expresses his trust and hope. Mingling the two things too closely, we ask, "How does mental health relate to theology?" It doesn't, directly, Dr. Hofmann believed. The only point at which they are related is in the effect theology has on the person and how he reacts to it. Even there, we must be careful. It is possible to convert people so that they acquiesce to what we say to them, but this does not mean that their trust, hope, and faith are independently established.

Dr. Oates observed that, as Santayana said, articulated dogmas of faith have importance in that they provide crystallized residuals of an on-going community of people. "They arose out of health-unhealth situations, and if reinterpreted into health-unhealth situations, they can speak to that problem in a definite way, about the many symptoms that people do not understand. 'Why do I do these things?' is the general complaint." The minister cannot accept the responsibility of removing symptoms; that is the doctor's job. But the minister can help by trying to translate the symptoms into some meaningful way of life. In spiritual conversations, doctrines tend to come alive again and existential situations in which the person discovers some larger patterns for his life and symptoms become less necessary to him. Dr. Oates firmly believed that one of the important tasks of the minister is to help the person to discover not the meaning of his symptoms, but the meaning of his life as a whole.

Returning to the patient in the back ward, Dr. Tompkins said he had observed what Dr. Oates had mentioned, though not necessarily in relation to the chaplain. Psychiatrists use what is called "companion therapy." The companion may be an undergraduate nurse, an aide, or anyone in the hospital. In cases where he had not been able to see any particular change in a dilapidated patient,

the nurse or aide would say, "Yes, it is there, I feel it" He asked whether this is the same process that occurs between the chaplain and the patient, or is there a difference? Should hospitals get more chaplains instead of more undergraduate nurses? Dr Oates asked why it was necessary to have just one or the other He said he believed in the priesthood of the nurse in this situation

Dr Blizzard went back to Dr Wolff's question addressed to Dr Oates about an operational definition that the group could agree upon for observation of the phenomenon Dr Oates had talked about the effect of communication of religious faith upon the mental health of the seemingly hopeless patient Dr Blizzard had deduced from the interchange that there is a possibility of arriving at some operational definition of a variable that can be measured If such a definition can be formulated, it will probably be seen that many other variables operate to make causal relationships between patient and chaplain rather difficult to establish

This fact seemed to Dr Blizzard to raise the question of whether the competence of the lay or professional therapist is not probably the significant item One does not like to give up reliable therapeutic methods, hence one gambles sometimes A student nurse or the chaplain will devote time to the effort to communicate a sense of the meaning of life, he or she will do it without counting the cost and without any confidence in the result If this is the case, it raises real questions about how religion however defined, can be depended upon to help us fulfill some of the meaning, the values, of our own concept of living

Dr Blizzard would be willing, he said, to give up the idea of trying to find an acceptable operational definition of the variables and just say that the change does occur He would be willing to see a certain amount of energy, of disposition of personnel, assigned to this function, without any measurement of whether or not it is going to be curative 'And then, I think, I get around to what Dr Klausner was saying what is faith?' Dr Oates added that a more clear cut clinical example of what he had been talking about is work with a patient who is going through the terminal stage of cancer or some other disease

By way of summing up, Father Salman observed that any formulation, be it of religion or the ultimate or mental health, if it is

general, will be so general that it has to be explained immediately by enumerating the different kinds of applicatioo. A general formulation is by definition abstract aod has no intrinsic content, or is merely a scheme within which one must enumerate different kinds of examples: love of God, withdrawal, acceptance, and so forth. The enumeratioo is useful because it allows a grouping of the whole and obliges ooe to specify all the important differences.

Practical Mental Health Implications

Discussion Leader:
HARVEY J TOMPKINS, M D

Discussant:
HAROLD G WOLFF, M.D

Practical Mental Health Implications

Having considered the interrelationship of religion and mental health from the viewpoints of sociology, anthropology, and religion, Chairman Klineberg said, the symposium members were now to turn their attention to the meaning of all that had been said to the person who has to deal with patients or to help people stay healthy.

Opening Remarks by Dr. Tompkins

In common with my colleagues, I have become increasingly interested in the contributions of the social scientist to the preventive aspects of mental health and to new conceptions of evaluation and treatment of the patient or group of patients I had expected that this conference would consider the social and cultural factors affecting religion in relation to the intrapsychic processes—what religion means to the individual—and as a social institution, which would add clarity to the role of religion in mental health The discussions have been fruitful, they have also added to the list of questions I had prepared before coming to Arden House

As psychiatry has broadened its scope, so has the training program and so has the product of that program—the psychiatrist 'Comprehensive medicine" is more than a catch phrase to the psychiatrist nowadays The profession is now as much interested in the biological approach as it is in the psychological I do not believe, as a result of my experience as an examiner for the American Boards, that a candidate could pass the Boards' examinations without knowing something about the pharmaceuticals, about the

basic sciences, biochemistry, neurophysiology, etc. He would need to know something about the contributions of anthropology and sociology and, to a certain extent, religion.

Social psychiatry is a matter of great interest at present. Psychiatrists are interested not only in the individual, but in his relation to the community. They are concerned with the community of the hospital as it relates to the community outside. There is much talk about the therapeutic atmosphere. All this is a change from the previous almost exclusive preoccupation with dynamic psychiatry. As the walls of the state hospital have been breached, so have the superimposed limitations of the psychiatrist.

The change began with the consideration of what is now a working hypothesis held by most psychiatrists: that mental health problems have a relation to early social experiences, to the interaction of the individual with the other members of the family, as Dr. Parsons had said. This early relation depends upon the experience with the mother and the rest of the family. The subject of the interaction between the child and his family, except for the point about the need for developing "hope" within the first two years of life, has not been dealt with here as fully as I would have liked. I had hoped to hear the sociologists say more about what the social organization of the family should be for the sake of better mental health, what further insights are needed into a more healthful family organization.

As for the community, I had hoped that more would be said about the role of the church as a social institution and its relation to the mental health of the individual. The social scientists have said that no definite research into the causal or statistical relationships between religion and mental health has been done. They have said also that religion is found in all human cultures, that it is an essential part of humanity. Certain statements have been made about the constructive or destructive possibilities of religion in relation to mental health, about the supportive value of rituals and the different capacities for religious experience of different societies. Discussants have said again, as Dr. Allport did in the symposium of last year, that one must consider not only the external evidences of religious practices, but also the nature of the religious experience in relation to the intrapsychic processes.

The first of my questions has to do with the many requests for recommendation of a Catholic psychiatrist that come to me I am not particularly sympathetic to such an inquiry I am a psychiatrist who happens to be a Catholic, which is an entirely different matter Nevertheless, if religion has this pertinency to one in sickness and in health, is it necessary to have a psychiatrist of the same denominational affiliation as the patient, and in what circumstances?

A related question is whether or not it is necessary for the therapist to know the religious denomination, if any, of the patient A good history, of course, would include knowledge of the religion of the patient, but I recently asked a group of residents, one after the other, to tell me the religion of the patients they had just seen, patients who had been having therapy for some time, only a few of them knew, though they could say that a patient was a Puerto Rican or a Negro or a Jew Perhaps this is a defect in our training program, if so, how can it be corrected?

Another practical implication of religion in relation to mental health has to do with the treatment of a non Catholic patient in a Catholic institution I am involved in the psychiatric service of a Catholic general hospital I am a Catholic and so are a number of the staff, others are not At any one time there may be a large number of Jewish patients in the hospital What are the implications for them of the atmosphere of the hospital—the crucifixes the presence of the sisters? How are these things involved in the total therapeutic situation? Are there pluses as well as minuses? What are they?

As psychiatry broadens its scope and the demands grow, there is need for more and more trained psychotherapists Some have said that therapists are born not made Some people are therapeutic because of their particular personality A psychiatrist uses the knowledge gained from scientific investigation to further his basic ability How does one evaluate this quality? How can the potentially good psychotherapist be ferreted out? All this is of importance in the training programs and in guiding the budding psychiatrist into a particular work

Listening to the attempts to define mental health in the preceding had no physical restrictions and have found limited constructive

The consensus seemed to be that it was a proper balance of different aspects of personality development. Trying to translate that into practicalities presents problems. For example, many states now have community mental health services acts intended to support mental health activities. Where do these activities end? Is mental health so broadly inclusive that every human act has mental health implications? If so, there are obvious operational difficulties.

The medicolegal problem presents a major difficulty, say, in developing a psychiatric service in a general hospital. The cost of liability insurance has tripled and quadrupled and more. My grandfather paid $25 annually for his insurance; I pay around $250. I have not yet been in court; maybe I would then pay more. Good medicine requires the use at times of a calculated risk, whether on the operating table or on a psychiatric ward.

The facility with which we can be sued and the exorbitant judgments rendered by some juries understandably may cause a physician or a hospital to hesitate in making an otherwise medically acceptable decision.

The question is not just a matter of paying more for liability insurance; it directly affects the welfare of the patient. What can be done to modify the adverse attitude of the general public? I recall that Dr. T. P. Rees of England, who has done so much in this area, on a visit to St. Vincent's Hospital went through the psychiatric pavilion and talked with the staff; he cautioned us not to be too far ahead of the acceptance, the receptiveness, of the community. How does one gauge that? How far in advance should a hospital be? Among the things our psychiatric services have done is to bring in volunteers, who can translate the hospital's work outside; to engage in public educational activities; to open the hospital doors to the public. What more can we do? We need help in determining the direction and effectiveness of community educational programs.

We talk about the therapeutic atmosphere in the wards. It is true that in some wards there is such an atmosphere. Essentially, this does not depend on open doors or the absence of bars at the window. There is a real community of interests involving everyone, and the patients apparently profit from it. I have visited wards that sessions, I noted how the term had broadened more and more.

activity, the patients and staff reacting negatively One day you might find this restriction, this tenseness, when the day before everyone was relaxed Something has happened You can't blame it entirely on the patients, their degree of disturbance, or anything of that sort Can you tell us what happens? Work has been done in this area, but we are in need of greater insights into our in-service training, our organization, our administration of the wards

Remarks by Dr. Wolff

I will first briefly outline my position, my attitude, and then speak as an educator concerned with the preparation of young persons for careers in medicine

Certain essential facts about the incidence of illness have emerged from a study of some 3,500 people made under my supervision Over a period of twenty years, about 25 to 30 per cent of the population accounted for about 25 per cent of the illness The length of illness, in days of absence from work, ranged from about 20 days in 20 years for the least sick to some 1,300 to 1,400 days in 20 years for the most sick The most sick had both minor and major illnesses, few people had only major illnesses Illnesses of the most sick included derangements of behavior, attitude, and mood called psychiatric illness, disturbances called medical, and disturbances called surgical

In this twenty year period, illness had clustered, there were poor periods and better periods Illness was not distributed evenly through the life span in most cases The clusters of illness occurred during the periods that seemed to be dangerous or threatening for the individual In other words, a neutral observer would find that all persons encounter dangerous situations, but some regard them as more threatening than others do

In my opinion, the healthiest persons are not necessarily the best or most attractive human beings, the sick are often, according to human standards, the better people

If all this be true—and it can be documented—what has it to

do with preparation for life in medicine? How does it bear on the concerns of this symposium?

At a recent meeting of some members of the Association of American Medical Colleges held to consider the teaching programs of medical schools, the current curriculum was reviewed. Let me sketch it briefly. During the first two years of medical school, the student is prepared in anatomy, physiology, biochemistry, pharmacology, and pathology. These are called the preclinical sciences or, wrongly, basic sciences. The next two years are taken up with bedside work; contact with the patient usually begins in the third or the latter part of the second year.

One group in the meeting of educators suggested that the medical curriculum had not kept pace with the extraordinary advances made by the scientific disciplines in the last twenty-five years, because it had not allotted additional time to the study of those so-called basic sciences. This group proposed that an additional one or more years be devoted to consideration of these rapidly advancing disciplines.

I see two fallacies in this reasoning. One is that if real progress is being made, there is unification, simplification, and deletion of disparity and conflicting evidence, so that actually there is less relevant material in these disciplines to teach. The other error is to attempt differentiation between the basic and clinical sciences. For instance, biochemistry in a medical curriculum is considered a basic science. Yet if one asked a nuclear physicist what he thought of biochemistry or physiology or pharmacology, he would say they are simply applied disciplines and in no sense basic. The difference between the "basic" and "clinical" sciences to my mind is largely a matter of where they come in the curriculum. For both, one applies the same method, the same attitude, and hopes to come out with inferences of equal value.

I think that something else has come in during the past twenty-five years that does merit consideration. Have the behavioral sciences now advanced to such an extent that they should be included in the curriculum, and where and by whom should they be taught, and how much time should be given to them?

An important fact was brought out in the meeting of medical

teachers A large number of professors of medical subjects had been asked to indicate on a graded scale how much significance should be attached, first, to the ability of a student to establish rapport with a patient, and second, to how much he knew about the setting, the social, religious, and educational background of the patient To my amazement, it was revealed that the anatomists, who are presumably occupied chiefly with the morphological aspects of the human being, expressed about as much interest in the student's possession of these abilities as did the professors of internal medicine, and both gave it a rather low order of importance

That is the problem How is one to meet this dilemma? Are the behavioral sciences going to supply what is needed in medicine?

The first thing needed, in my view, is a teacher who, along with general capability, has an enduring interest in man, a love of man, a curiosity about him, a respect for his aspirations, a compassionate attitude toward his foibles, a feeling of responsibility for man's being The teacher also must have an understanding of the scientific method, which to me includes a desire to impose order upon the disorganized mass of information on the above topics as well as a knowledge of the logic of inference, and some ingenuity in devising situations that allow inferences

Are we sure that the behavioral scientists will bring to the medical school faculty those elements of love and interest and compassion and responsibility? Understanding of the scientific method would probably include curiosity about man, but it might not be accompanied by the love and compassion Is it necessary or desirable to bring to the undergraduate medical student a new discipline that would teach him the facts of man's social and psychological experience, and would this new discipline give him the other attitudes mentioned?

One of the difficulties with medical education over the last half-century has been the great success of medicine, success growing out of the application of methods that were extraordinarily telling in the analysis of dead stuff and inert material, the chemical and physical methods The biologist, in order to gain prestige in his own eyes, often turned his back on living stuff to ape the physicist

cation be experienced before entering medical school. At least one can say that not everyone is satisfied with the present arrangement, but the 'hard sciences' are still in the saddle."

Attitude of High School Students toward Science

A study of the attitudes of high school students toward science made in 1956, Dr. Mead said, showed a decided and widespread sense that science deals only with dead things—dead atoms, dead stars, dead rocks—with no recognition at all of living things. Biology means dissection, in which the animal either is dead or soon will be. Physiology is regarded as something relating to "organ systems," well outside the body and operating on a diagram. Some children said, "I don't want to go into science because I like plants," or "because I like animals." The only human science that was mentioned was archeology, which meant to the children dead men and dead cities filled with dead pots. Some girls wanted to marry doctors and expressed compassionate attitudes toward life. The whole set of responses was rather stereotyped. The students wanted to benefit mankind, to do big things. But most of the girls, and the boys whom they would normally marry, if they wanted to be scientists at all wanted to be nuclear physicists and go into outer space, blowing up a fair number of things on the way. There were only very low levels of compassionate attitudes.

A study of the difference between adolescent girls' and boys' attitudes recently made in Switzerland indicated that the girls wanted to mend, to repair, to patch up, to cure, while the boys had very little of this interest.

Perhaps, then, Dr. Mead continued, one of the things we ought to be thinking about in directing the attitude toward science all through the country, an attitude that will be the precursor to a vocational choice, is the extent to which choices are being made at the high-school level, and the readiness of both boys and girls to see science as alive and a scientific career as one having to do with people.

Recalling Dr. Adolf Meyer's admonition to keep psychiatry out

of the deadhouse, Dr Humphreys said he had been deeply moved by the statements made about training for medicine and its branches, the practice of psychiatry in the hospitals and clinics and in community mental health services He said he could hardly overstress his feelings about these things, and wanted to extend the thought into one more area of service government Practitioners of medicine and psychiatry who had gone into state administrative work could testify painfully to the desperate need for anthropologists, sociologists, psychologists, and theologians to get into government Politics should be domestic statesmanship, not just ward healing Somehow or other, Dr Humphreys said, he felt that new meaning should be given to the relationship of church and state The church still has a ministry to the state, and the state in turn can serve the church

The Sociologist's Involvement in Mental Health Studies

Dr Sills, eschewing defense of the compassion of sociologists, added a word about their involvement in mental health He quoted Dr Marie Jahoda, speaking at the Bureau of Applied Social Research at Columbia, suddenly withdrawing herself from the present and remarking, "Sometimes I think that maybe we are not working with anything real here, that we are part of a social movement of which people a hundred years from now will say, 'Look at those people in the twentieth century, they were all caught up in something called mental health, which now has almost a medieval ring to it' "

Sociologists are very much caught up in this social movement, Dr Sills said Some of the evidence is that in the American Sociological Association there is a new section on medical sociology, which is enormous in size The Health Information Foundation publishes annually a list of research projects in medical sociology that is growing rapidly every year The National Institute of Mental Health is making more and more grants for sociological research every year, its budget for 1960–61 is approximately double the

present amount. The number of sociologists who are residents in medical schools and in mental institutions, partly through the Russell Sage Foundation's residency program, is growing all the time. The Bureau of Applied Social Research for a number of years has been studying medical education as a social process, getting at some of the things Dr. Wolff had been talking about. The major problem, as Dr. Sills saw it, was not money or interest, but getting some of the best people in the field of sociology to work in mental health.

Dr. Klineberg added that the International Sociological Congress recently held in Stresa, which he and Dr. Parsons had attended, had had a session dealing with sociological approaches to mental health.

There is improvement going on, though it may not be fast enough, Father Ewing observed. Referring to what Dr. Mead had said about motivation in the study of physical and social science, he said he believed it was necessary to go back to grade school. He had been involved in a faculty seminar on the problem of science in our culture a few days ago. They had been unable to find anything on the college level and had therefore turned back to high school and grade school.

Overspecialization of Science

Father Ewing also endorsed what Dr. Wolff had said. With our atomistic experiments and bits of knowledge about what was once living or nonliving matter, we have learned a tremendous amount, but in the course of it we have tended to throw out the cart and keep the horse going. In the field of evolution, for instance, in which Father Ewing was interested, it is a rare spirit who will dare, as did Pierre Teilhard de Chardin in his book *The Human Phenomenon*,[1] to come out and say anything about finality in the liv-

ing process, either in the individual or in the trend of evolution "This is, of course, very bad taste, because it is only pure chaoce and there is no finality at all, even though one does end up with something, strangely enough But Teilhard de Chardin tried to reconcile the two, both the chance and the evolution" Father Ewing highly recommended Teilhard de Chardin's book, which has now been published in English, as the most successful effort to date to put these two opposing concepts together

Biology and the Behavioral Sciences

Further underscoring of Dr Wolff's remarks came from Dr Parsons "As one looks at the American intellectual scene, ooe sees n curious relative eclipse of the biological sciences 10 the last gen eration or two It seems that physical and chemical sciences are at one end, with the still very amateur but undoubtedly important development of the behavioral sciences at the other end, the intel lectual prominence of general biological sciences seems to have re- ceded" Father Salman offered a qualification of this statement He thought the science of biology, whicb he observes from the point of view of animal psychology, bas developed very happily It just isn't recognized oo the intellectual scene

Biology is of tbe greatest importance to the behavioral scientist, Dr Parsons cootinued But the same tbing tbat Dr Wolff had men tioned as happening in medicine often happens also among be- havioral scieotists unfortuoate apiog of physical science, taking it as *the* single model of tbe truly scientific There seems to be a curi ous gap that perhaps will be filled again Dr Parsoos agreed with Father Salmao that some extremely interesting work is being done in the biological sciences but it is not salient

Dr Mead noted that at some periods in the development of sci ence it is important to stress man s difference from other living creatures, and in other periods it is fruitful to deal with the fact that he is a liviog creature among other living creatures The new work being dooe by ethologists is now serving as the link between

man and his companion creatures. We know, thanks to the ethologists, that more interesting material about evolutionary development comes from the study of birds than from observation of mammals. Recognizing the importance of the ethological movement, Dr. Klineberg added that experimental work in social psychology being done at the University of Wisconsin and at McGill University, with a somewhat more biological emphasis, is important, too. Both the observations of the ethologists and the laboratory type of research in animal psychology are needed.

Social and Individual Adjustment to Change

Dr. Wolff asked another question. He believed that rapid or violent change is a threatening aspect of human experience. For example, it is widely known that mortality from tuberculosis reaches a peak within ten to twenty years of the industrialization of a community and thereafter falls off sharply. It could be demonstrated, he thought, that crowding, lack of food, lack of good air, deprivation in other material things were not by any means the only factors in the increasing incidence of the disease. Industrialization causes a complete disruption of a community. It requires a completely new set of guideposts and criteria and beacons. The individual takes some time to find his way about in the new order, and while he is in that precarious state he gets sick. It had taken thirty to forty years for the Russian society to become industrialized; it will probably take the Chinese about half that time. In India, it may be done in ten years.

The question Dr. Wolff wished to ask was this: How can we enable the human being to meet this speed of change and to find some path through the catastrophic period when everything is disjointed, when his elders, his mentors, his parents, his teachers are no longer in a position to guide him?

The limited quantity of field material now available on this subject, Dr. Mead said, suggests that the catastrophic element is am-

biguity and discrepancies in the kinds of change [2] If the change is rapid and complete enough, it is not so upsetting For example, if a family is moved from an agricultural community into an industrial one where the housing, the clothing, the habits are completely set up so as to fit the industrial life, there is not the same degree of disruption as occurs when people are allowed to move into the city bringing along a donkey and their country clothing and habits of living and then find they have to get rid of the donkey and change some habits but not all The resulting confusion is catastrophic In the country, people living as peasants have food that keeps them alive It includes wild berries and black bread and such things, it is a balanced diet When they move into the city, their nutrition becomes much worse, almost invariably, in the transitional period Coming from their country setting, they are suddenly confronted with one room and no place outside to throw the garbage, so they throw the garbage inside, and there are slums The woman who stays at home is not changed in the same way as the man who goes out, hence the whole marriage relationship is upset Women are separated from their relatives instead of living in the community where their relatives also live The complete transformation would include the grandparents, too

If it were possible for people to move directly into a completely new pattern of living, so that the transformation could be immediate and total, there would be no period of disorganization and gradual reorganization The painful and confusing transition was necessary when there were no models, and it may still be necessary for the people who are furthest ahead of the game, because they do not have any models But we have perfectly good models now for living decently in an industrial society There is no longer any need to go through the slum conditions, overcrowding, child labor, long work days, bad nutrition, and so on

[2] Mead Margaret Cultural Discontinuities and Personality Transformation " *Journal of Social Issues* Kurt Lewin Memorial Issue Supplementary Series No 8 1954 Mead Margaret, Cultural Factors in Community Education Programs *Community Education* the 58th Yearbook of the National Society for the Study of Education Part I ed Nelson B Henry Chicago The National Society for the Study of Education 1959 66–96

Dr. Mead saw two things as necessary: the setting up of good models so that the change can be made across the board, and providing a kind of education that prepares people for a series of transformations within their lifetime so that they will not find change disruptive. If people were brought up in the expectation that they would be living differently probably ten years later, and then again perhaps twenty years later, with still another change possibly thirty years later, and if this expectation were passed on from generation to generation, then changes need not be catastrophic.

Dr. Wolff asked what about the identification of the child in the change: after whom does he fashion himself in the new situation? What is his model?

"The adults have to move, too, you see," Dr. Mead replied. "I think we have to give up this notion that people of fifty can't learn; it is utterly disproved by any look at the data. People of fifty are usually much more capable of learning transformations than children are. Children can learn something entirely new more quickly, but an adult who has learned how to learn languages and already speaks five can learn a sixth better than a fifteen-year-old knowing one language can learn a second. If we see changes as systematic transformations, there is no reason why adults can't make them. If my savages—women who twenty-five years before were wearing grass skirts and bones of the dead in their arms, with their ear lobes pulled way down—could be transformed into responsible members of the community who could invent a P.T.A., the people in our society ought to be able to do better." [3]

"Would the religionists carry with them a tradition that would be important in this regard?" asked Dr. Wolff. "Would it supply a means of bridging the gaps?"

Dr. Mead thought that religionists could supply a sense of continuity during the transformations that are brought about primarily by technological factors. "Look at the way the Hutterites take to machinery," she said. "They are one of the most conservative religious groups we know anything about, but they can take in one

technological change after another, better than most communities do, because they have their central sense of continuity"

Mr Wolfson cited Israel as an illustration of the kind of thing Dr Mead was talking about The agrarian Yemenites are coming into an entirely new environment, making a drastic and rapid transformation successfully Dr Mead commented that Israel has done very well with forty year olds, but does not transform the still older people, the country s labor laws, pension system, etc are so good that they put their older people on the shelf, treat them magnificently, but do not transform them

Social Science Studies of Value Systems

Noting that two members of the group had spoken about the purposefulness of man's behavior, his need for goals to work toward, and the importance of this concept in psychotherapy and dynamic psychology, Father Devlin asked the anthropologists and the sociologists whether they could suggest any techniques for learning about value systems and the goal directed, purposive behavior of man Everyone seemed to acknowledge the importance of these qualitative attributes in the totality of the individual and the social scientists present had admitted the inappropriateness of borrowing the methods of the physical sciences to study such matters How, then, can they be approached?

Dr Mead, noting that she was speaking only for one group of anthropologists, said that since the introduction of the across the board model, the cybernetics theory, it has been possible to include the image of the future in any sense that one wishes—in the information contained in the genes, in identification with elders, on any level of the mechanisms recognized as controlling human behavior One can look at growth, for example, as Erikson does[4] and find it completely purposive and directed It is no longer neces

[4] Erikson Erik H, *Childhood and Society* New York W W Norton 1950

sary to bring an external teleological feature into the system, an importation that used to upset scientists before the publication of the pioneering paper by Rosenbleuth, Wiener, and Bigelow.[5] Since the appearance of that paper, a great many anthropologists, sociologists, psychologists, and animal experimenters have been able to deal with problems of motivation and behavior and to collect a mass of factual information within this frame of reference. Many people are not yet doing this kind of study, and some, now dissatisfied with the cybernetic model developed in the late 1940's, want to go on to greater complexities in it. But Dr. Mead considered the kind of study Father Devlin had asked about to be no longer a problem, at least for anthropologists.

Dr. Parsons reported that many attempts are being made by both sociologists and anthropologists to study quite explicitly the problem area of values and their role in behavior. He himself had been concerned with the area, and Dr. Clyde Kluckhohn had been giving it his main attention in recent years. Participants in a large field research project in the southwest United States had chosen five rural communities with different cultural backgrounds and had been studying them from the point of view of values and their relation to various features of the structure of the communities, the kinds of strain they produced, and the reactions of the communities to the strains. This field of studies is receiving a good deal of attention from sociologists and anthropologists, Dr. Parsons said.

Dr. Klineberg added that the same thing is true in psychology. Two social psychologists in this group—Dr. Allport and Dr. Watson—have been interested in the problem for many years.

Adding a note from the psychologist's point of view, Dr. Allport said he thought that that discipline was just in the stage of trying to get hold of the most significant dimensions of the individual's faith and attitude. He believed little progress had been made. Re-

[5] Rosenblueth, A., Wiener, N., and Bigelow, J., "Behavior, Purpose and Teleology." *Philosophy of Science, 10,* 1943, 18–24; Ruesch, Jurgen, and Bateson, Gregory, *Communication: The Social Matrix of Psychiatry.* New York, W. W. Norton, 1951; Frank, L. K., Hutchinson, G. E., Livingston, W. K., McCulloch, W. S., and Wiener, N. "Teleological Mechanisms." *Annals of the New York Academy of Sciences, 50,* 1948, 178–278; Mead, Margaret, "Psychologic Weaning: Childhood and Adolescence." *Psychosexual Development in Health and Disease,* New York, Grune and Stratton, 1949, 124–35.

calling Dr Tompkins' question about whether hospital staff should find out the denomination of the patient, Dr Allport said he thought that would be elementary knowledge, but not significant The important question is, what is the place of religion in the patient's life? What is his purposive striving, as Father Salman puts it? Beginnings have been made in the analysis of religious attitudes, such as a study of religious values, but that phrase points just one way A study by Toch [6] indicates patterns or linkages of religious attitudes that do not correspond to denominations, which is an important negative finding Dr Klausner's model of the ingredients of faith is useful But Dr Allport believed that one of the most elementary research needs for the psychologist was an analysis of the dimensions or types of religious attitudes in people That would shed light on the purpose and nature of man, it would also be of great help to the psychotherapist in action

"I have a notion," Dr Watson said, "that what we have said, while true, does not answer Father Devlin's question I wonder whether what he meant was this is there any tendency in the behavioral sciences, first, to ask what is the chief end of man and then to derive other things from that approach? As far as I know, that is not characteristic"

Dr Kolb remarked that bringing values and purpose into social studies within an essentially deterministic frame of reference and stressing the socialization and internalization of purposes and values into the personality of the child through role interaction do not quite answer the question A critic of Nisbet's book, *Quest for Community*,[7] had called its definition of freedom parochial, a sociological definition would mean simply that there was a set of mutual consistencies between the internalized ends and purposes shared by the culture, that the means chosen were adequate to produce a smoothly functioning society, and that in such societies there might be some of Nisbet's bogeys—National Socialism and other forms of totalitarianism Dr Kolb was somewhat bothered about the exclusion of Nazism from the definition of a culture by the test of its viability, the criterion of survival He thought that

[6] Toch Hans, and Anderson, Robert, "Religious Belief and Denominational Affiliation." *Religious Education* May–June, 1960 193–200

[7] Nisbet, Robert A., *Quest for Community A Study in the Ethics of Order and Freedom* Toronto, Oxford University Press, 1953

the prohlem was to learn how sueh a soeiety makes its shared ultimate eommitments in the first place, before they have become part of the culture and have been transmitted through the process of socialization and social interactinn.

Father Salman commented on the problem of developing a sense of the human element, the human contact, and sn forth. He considered it important to realize that the child originally has this sense; he develops it during his primary experienee of learning to deal with people, his mother first, and other persons later. The modern scientific approaeh is develnped later and superimposed upon the earlier capacity for interpersonal relations, when the child learns to manipulate physical bodies and acquires teehnical skills. The prohlem is not to lose the primary sense while acquiring the scientifie point of view. This awareness is important both for the question of contact and for the general prohlem of approach to religion. The ehild is religious tn hegin with. He has that type of relation, animism in the pure sense, that is not a high form of religion, hut that is the kind of relation out of whieh religion develops, whereas the seientific development is an aside.

Dr. Tompkins had more questions to add to his list. First, he referred to Dr. Allport's remark ahnut the knowledge of the patient's denomination. He felt sure that all the residents in his hospital had this knowledge in the heginning; the significant fact was that they lost it somewhere in the therapeutie sessions, prohahly heeomiog preoccupied with the meaning of religion to the patient. Dr. Tompkins had meant tn ask whether the denomination itself is less significant in the therapeutic relationship. Isn't it necessary to keep in mind both the denomination and the meaning of religious experience to the individual? He was trying to get at the significanee of religion as a social agency in regard to mental health.

Cultural and Social Factors and Psychotherapy

Dr. Tompkins' additional questions had to do with the effect of cultural factors on psychotherapy. It is agreed that the indices of mental health vary in different cultures. How do these differences

enter into the therapeutic relationship when patient and therapist are of different cultural backgrounds? This is a practical question, because there are many foreign born graduates on the staffs of our state institutions, and there are many foreign born patients, too In New York, in his own hospital, for instance, there are many Puerto Rican patients being treated by psychiatrists born in this country and in Europe Difficulty of communication, not only in language but in other areas, is a serious problem It is not only a question of language-barrier, but also a lack of knowledge of the social and cultural characteristics of the patients It is in these latter areas that most help is needed, especially from anthropologists and sociologists

A related question is, what are the implications in the therapeutic relationship of class differences within our own culture?

Then there is the question of relation among the patients themselves In most state hospitals and in many of the psychiatric services of general hospitals, patients from different cultures and from different classes room together, eat together, recreate together Dr Tompkins said he had been criticized by some of his colleagues for placing a private, paying patient in the same room with one who is under city auspices He wanted to know what are the implications

Religious Denomination of the Psychiatrist and the Patient

Father Bier turned back to one of Dr Tompkins' first questions, that of the advisability of the patient's choosing a psychiatrist of the same denomination as himself A distinction between the theoretical and practical levels of this question seemed necessary to Father Bier, a distinction, that is, between the scientific and practical aspects of medicine and psychiatry It is frequently said, as it has been in this conference, that science is a neutral thing, and therefore without any particular religious implications On the scientific level, Father Bier agreed But medicine is not only a science, it is also an art From the practical art standpoint, he was not so

sure the religious implications could be overlooked. It might not be necessary to make a requirement of religious compatibility between patient and therapist, provided the psychiatrist was reasonably well informed about the religious attitude of the patient. This, however, cannot be taken for granted; sometimes the psychiatrist's ignorance on this point is astonishing.

In the kind of collaboration between religion and psychiatry of which there have been conspicuous examples in recent years, Father Bier thought there had been more willingness on the part of the clergy and religious people to find out about psychiatry than on the part of psychiatrists to find out about religion. He wondered whether some factual acquaintance with religious differences to be encountered among patients could not be incorporated in the training of psychiatrists.

On the practical side of Dr. Tompkins' question, Father Bier had found that, because of the old climate of suspicion and hostility between religion and psychiatry, a good many Catholics cannot be brought to accept any but a Catholic psychiatrist. This fact is not desirable, but it exists. Because of it, he felt that he made a contribution as a priest when he could persuade such people to accept psychiatric help; without his influence, or that of someone in a similar position, they would not do so at all. Whether or not their anxieties are well founded, often the only thing the priest can do is persuade the person to consult a Catholic psychiatrist.

Dr. Meserve added that he thought most Protestants would probably prefer a Protestant psychiatrist, or possibly a Jewish one.

Much of the problem depends upon the individual psychiatrist, Father Devlin observed. If the patient finds that the psychiatrist respects his denomination or his religious experiences, looking upon them as ego strength, as Karen Horney used to do, he will accept the psychiatrist readily enough. The Holy Father has said that it is not necessary to have a Catholic psychiatrist; the need is for a moral man who will recognize the moral and religious principles of the patient. Unfortunately, many psychiatrists have spoken out against religion. There are differences in training. Many non-Catholics are wonderfully trained; if they are also moral people with consideration for the patient's religion, they are good men to refer to. Dr. Tompkins asked whether respect was enough, though

of course it presupposes a certain amount of knowledge of the de nomination Father Devlin agreed that knowledge and background were important, too Certainly, be said, if one can find a well trained Catholic psychiatrist, it is better to refer the Catholic pa tient to him

Rabbi Hollander reinforced what Father Bier had said, adding that it depends on the type of psychiatry espoused by the psychiatrist as well as on the kind of person be is For instance, a psycho analyst using classical Freudian technique would not need to be of the same religious denomination as the patient, because the classical Freudian approacb usually does not deal with problems on a denominational level

On the other hand, if the patient is aware that the psychiatrist or analyst is not just neutral but is bostile to the idea that religion can have n positive role in people's lives, that attitude will intrude upon the doctor-patient relationship during the period of treat ment Rabbi Hollander believes then that it is important to choose a psychiatrist who recognizes that religion can have a great deal of positive value to the patient

Dr Watson suggested that one of the difficulties of the therapist who is not well informed about the varieties of religion is that he is intimidated by the whole area of religion and hence is unable to discuss the patient's problems effectively He thinks he is helping by saying, "Of course, that is quite all right," when it may not be all right at all The way in which the patient is using his religion may be a part of his sickness and something that must be dealt with Therefore Dr Watson agreed strongly with the statement that psychiatrists need more awareness of the meaning of religious experience, the varieties of it, the organizational forms it takes, and the personal depth levels achieved by it He did not know how this knowledge could be imparted, perhaps the Academy could make it a project He felt sure that the crowded curricula in psychiatry and clinical psychology left little room for adequate courses of this kind A primer might be of some value, but he doubted that it would be very useful Probably supervision during the training period, work with people of various religious types, and things of this kind would be the best way of working this kind of training into the preparation of the psychiatrist or other psychotherapist

Taking up another question raised by Dr. Tompkins, Dr. Watson said he thought the matter of class was even more difficult to handle than that of religion, in many respects. Certainly it proved to be so in education. It is very hard to educate children from the lowest class, because most teachers cannot make any effective contact with the values, experiences, feelings, and aspirations that elementary school children bring from their underprivileged background. He would be interested in knowing the results of Dr. Tompkins' grouping of people in the hospital across class lines, but he was not hopeful of good results from it. Children's camps in which this has been tried have not been successful. Interracial camps are much easier to run than cross-class camps. It may be, Dr. Watson thought, that the inability to transcend class barriers is a kind of blind spot in the training of psychiatrists and psychologists.

It is important to make sure, Dr. Mead said, in talking about denomination, whether you are talking about religion or culture. For instance, all the Catholics in a group may be Irish, and all the Jews may be Hungarians, and what people think is religion is actually national culture. The psychiatrist ought to learn to sort out these things in trying to find out what the problems are. When a German Catholic psychiatrist is working with a German Jewish patient, there may be more lines of understanding than in the case of an Eastern European Jewish psychiatrist working with a German Jewish patient. In about half the cases where people talk about religion as the barrier, Dr. Mead thought, the real difference is in social organization and culture, class, region, or nationality.

Another model that might be useful, Dr. Mead continued, is one developed in Dublin by Professor O'Dougherty, who is a Catholic priest, a professor of philosophy and psychology, and a good psychotherapist. He has had working relationships with Protestant analysts who, after they have treated their patients for some time, send them to him for a short period of reorienting their lives and considering their life choices, a point at which their contemporary ego values are important. In large cities, where there are so many facilities, it might be possible to arrange more co-operation at the point where value choices are to be made; consultants from the

on a basis that cuts across denominational affiliations In certain respects, education goes as deep into fundamental values and life problems as does psychiatry

Labels

From his contact with medical students, Dr Wolff said he had gained the impression that there is a reluctance to admit the existence of social stratification in our society This appears in the way a student will describe a patient she is a "thirty-six-year-old scrub lady," for example It is an attempt to dignify the person "Woman" is considered a degrading word, either "lady" or "female" is used There is no understanding of differences in experiences, irrespective of whether one is better than the other He asked whether other members of the group had noticed the same thing

Dr Mead said that she and others had done some work on this kind of thing with nurses and had made some progress Nurses were being taught that it is undemocratic to mention anyone's religion, class, race, or national background So one gets a "middle-aged obese female," which corresponds to the "scrub lady " Nurses and medical students should be made to understand that it is not denigrating to mention the religious or national or racial background of a person Dr Mead suggested that the Academy might make a research task of preparing materials to teach students, nurses, and psychotherapeutic personnel how to deal with these differences Recently, as a consultant in a mental hospital, Dr Mead said, she had shocked members of the staff by asking Negro staff members to discuss Negro cases When discussing a Negro patient, one was supposed never to mention the fact that there was a Negro nurse or social worker in the room

This raised the whole question of the use of labels in describing people, Dr Klineberg said The American tradition is that a label involves some kind of hierarchy, a higher or lower level, and therefore we suspect anyone who uses labels. We don't like to hear people refer to a Jewish doctor or a Negro nurse In other cultures

there is an entirely different feeling. For instance, in Hawaii everybody uses labels. Someone will ask, "Do you know so-and-so?" and the answer will be, "Oh, yes, he is half Japanese and one-quarter Filipino and one-quarter white." People say such things about themselves without the least self-consciousness. It is just a way of describing the individual, like saying that he has red hair or blue eyes. In the same way, they will say, "He is a Buddhist," or a member of some other religious group. We, on the other hand, worry about the label as meaning some kind of reduction in status.

Influence of the Future on the Present

In connection with Dr. Tompkins' and Dr. Mead's remarks about models, Father Mailloux suggested as a research project for the Academy that there be some attention paid to the problem of the influence of the future on one's present life. "In psychotherapy, most of the time we concentrate on the causality of the past; if we look at values, of course, we have to look at the past and the future as well—that is, the implementation of the values—because the future is a potential reality, with a definite causal influence on present behavior. This aspect is entirely forgotten most of the time in psychotherapy. I think it has direct implications for the attitudes of psychotherapists. The whole meaning of teleology is forgotten. Looked at philosophically and metaphysically, it means contact with reality and with a concrete reality. If you want an automobile, for example, you buy a real one, instead of just dreaming about it."

Dr. Klineberg remarked that Janet had said that, for him, one of the most important characteristics of the mentally healthy person was that he was not bound to the past or the present, but could look forward to the future. "And the far future," added Father Mailloux.

To emphasize what Dr. Mead had said about the cultural dimension of what is usually classified as religion, Dr. Oates cited an example growing out of an interview he had had with a Negro

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To emphasize what Dr Mead had said about the cultural dimension of what is usually classified as religion, Dr Oates cited an example growing out of an interview he had had with a Negro

student at the Southern Baptist Seminary. He had said, "When we Negroes find a Baptist church that is sufficiently sophisticated and developed to accept us as members, it usually turns out that the church has religious practices or forms of worship that are totally alien to the background from which we come, and we feel ill at home in it." This seemed to be a canny insight into the kind of thing Dr. Mead was talking about.

Religious Education Compared with Medical Education

Turning then to what Dr. Wolff had said about medical education, Dr. Oates spoke of a point made in a recent three-volume study of theological education by Niebuhr, Williams, and Gustafson.[8] The authors reported that the teachers in theological seminaries look upon the education of the student as being confined to the three or four years that he spends in the seminary; hence they do not develop in him an openness that will make of his whole life a continuing educational process. The theological schools, as do the medical schools, find their curriculum too crowded to allow enough time to teach the new knowledge derived from the behavioral sciences. They have to take summers and the fourth year on the basis of voluntary persuasion to get this material across to the student. But a fundamental defect in theological education is the regarding of the student's education as finished when he gets his degree.

As supplementing what Dr. Oates had just said and referring

[8] Niebuhr, H. Richard, Williams, Daniel D., and Gustafson, James M., eds. *The Purpose of the Church and Its Ministry*, 1956; *The Ministry in Historical Perspectives*, 1956; *The Advancement of Theological Education*, 1957. New York, Harper and Brothers. The three volumes resulted from the Study of Theological Education in the United States and Canada sponsored by the American Association of Theological Schools.

also to Dr. Wolff's statement, Rabbi Hollander said it seemed a little strange that, although religion's concern is to help people live more fruitful lives, religion in the last fifty or sixty years does not indicate that it has been much more successful in attaining this goal than has science. He thought that part of the problem was, as Dr. Oates had said, the result of the system of education in theological schools, which is not as effective as it should be, both from the standpoint of introducing new subject matter and from that of teaching methods. Religious subject matter is presented with little relevancy to the resolution of daily problems and crises of living This is one of the reasons why many students enroll for clinical pastoral experience to hospitals and other institutions. The remark is often beard, "I have learned more about what religion can do for humanity in six weeks in the hospital than I have heen able to derive from my seminary experience."

There is another problem besides education, Rabbi Hollander continued. Even with the best educational system, incorporating all the newest and best ideas, there is still much to be done in the way of a break-through by which religion can come closer to dealing with man as a living being. For thousands of years, religion has preached the philosophy of life, and yet it has not become part of man to the extent that it should have. Not just education is involved here. A new approach, or a new method, must be found to reach the human being.

Dr. Sills noted that the Bureau of Applied Social Research has been conducting a continuing study of medical education stimulated by, among otber things, an even longer-term interest in the sociology of professional people and how such people acquire professional attitudes. Some members of tbe Bureau staff think that theological schools might have been an even more exciting setting for such research, and hope to undertake a program of research into theological education.

The student in a theological seminary, Dr. Blizzard remarked, has been inhibited in his ability to become a practitioner of religion by an image projected by tbe seminary teacher. The teacher is so far away from the practice of the profession and so tied up

in professional struggles and concerns that he considers the student capable who comes close to his image of the scholar rather than to the image of the practitioner in the parish. Dr. Sills observed that this is much less true in medical schools. Dr. Blizzard said he had assumed that was the case. He thought it a problem of divinity education that would have to be solved, or else there would have to be a whole new system of post-seminary education. What Rabbi Hollander said about the rush of students to the hospitals and prisons and clinical training programs, in which they acquire knowledge about behavior and culture, should be incorporated into seminary teaching. There must be a readjustment of the image held by the faculty of what the practitioner is going to run up against, or there will have to be a supplementary training program. Dr. Blizzard did not mean to recommend any lessening of the requirements of technical religious study in the seminary, but he did advise the giving of focus and meaning to what the student will be doing when he has completed at least one step of his professional education.

Dr. Wolff said that about twenty years ago, a higher proportion of the top-ranking students in the nation's colleges were going into medicine than are now doing so. He asked whether the same thing is happening in the world of religion.

Rabbi Hollander reported that from his point of view this was unfortunately true. By and large the brighter student is being attracted to the sciences, perhaps not so much because of financial rewards, but because science seems to offer him greater possibilities of knowing and understanding man than religion does.

Speaking from the point of view of Protestant theological education, Dr. Meserve told of an experiment conducted by the Rockefeller Brothers Fund. The trustees have set up a Theological Fellowship Program with a full-time director who goes around to college campuses and picks out good students who are not at the moment considering the ministry, presents the ministry to them as a possibility, and offers them one full year at a seminary on a fellowship. The hope is that in this way outstanding students who might otherwise become lawyers or doctors or something else may be given a chance to think of the ministry as a vocational possibility. The results have been interesting. As of June, 1959, 187 Fellows have

completed one or more years of seminary, 65 have returned to lay activities, 33 are working toward the B D or Ph D in theology, and 89 are planning to enter the parish ministry

Dr Hofmann reported a sharp change at Harvard in recent years A numher of ahle, intelligent, and successful college graduates expressed a desire to go into theology, but their condition for going into it was that they would not have to go right through the theological course and ont They felt that the Harvard Divinity School opened up possihilities for studying other disciplines, too

Speaking of the Loyola University program of preparing and evaluating materials and methods for better training of Catholic clergyman, Father Herr said he and his colleagues were committed to a research program, hut that in getting started on the evaluation they had interviewed a great many seminarians from different strata and a numher of clergymen As Dr Blizzard had indicated, one of the responses met with in all the interviews was the comment that the student is not given enough preparation in dealing with people The same response comes from priests who have been out of the seminary for five, ten, or fifteen years The longer they have been out of school, the more they say, "Why didn't we have teachers who had been out in the field, working, instead of theoretical theologians?" Finding the situation very interesting the persons conducting the study also face the difficulty of establishing a methodology for research in the area of attitudes, especially attitudes toward mental health, psychiatry, psychology, and such things

Dr Oates reported that in a study of 500 men made at the Southern Baptist Seminary it had been found, surprisingly, that about 20 per cent of the men entering the theological school had come after several years of experience in other post-college kinds of work, after having achieved a certain level of success in other fields The school was encouraging these students, because their previous training bad included some other disciplines and probably some preparation in the behavioral sciences

Having worked for some ten years in the evaluation of applicants for a certain segment of the clergy, Father Bier said that his overall impression was that, although the average is high, the very top students were not going into the profession The Catholic priesthood, Father Bier continued, differs from the Protestant ministry or

the rabbinate in the irrevocability of its commitment. This means a more mature consideration of even the initial choice. The study that Dr. Meserve had described was an interesting idea, but Father Bier could not conceive of Catholics proceeding in any such way.

Dr. Hofmann said that at Harvard he and his colleagues had made a study of ministers, pastors, or counselors who had been in the ministry for some time, trying to find out how their later attitudes had replaced their theological training. They had also questioned parishioners in the same areas who had had counseling contacts with their ministers and others who had not. The studies had revealed that things were really quite different from what faculties of theological seminaries had assumed to be the case.

Role of the Sociologist in Multi-Discipline Discussion

Dr. Blizzard brought up a question that had been troubling him as a result of the two Academy symposia he had taken part in. The members of both groups were people interested in the relationship between religion and mental health. In general, the participants have been persons both interested, in varying degrees, in religion and trained in some of the specific religious traditions. Who, then, is the person who helps the group understand itself and gain perspective on the two basic subjects about which they are jointly concerned?

In another meeting that he and Dr. Oates had attended, a gathering dealing with motivation for the Protestant ministry, a psychiatrist had remarked that the sociologists in the group were not being sociologists; they were being pastors. It was true; they were somehow apart from the group, every once in a while playing the role of getting a perspective on the situation. Dr. Blizzard did not know how such a function could be performed with this symposium, but he thought it necessary, because the members become too involved in the discussions. He raised the point as a procedural problem in exploring relationships between religion and mental health.

Necessity for Political Realization of the Religious Ideal

Referring to what Rabbi Hollander had said about the fact that religion has for a long time been preaching the importance of the living being, and the need for a break through, Dr Mead said it seemed perfectly reasonable to expect that religion would preach things for a long time before they became possible We must consider the entire growth of modern medicine as having been preceded by a religious view, a compassionate view, of the individual

"It is important to realize," she continued, "that this is the first time in human history when it has become practicable and necessary for all human beings to be considered politically in the way they have been considered religiously for a long while We have had the religious vision of the unity of mankind, of all human souls being equally valuable to God, for a long time, while warfare remained with a great many human values that were hard to combat

'This is the first time in history when we are confronted with the necessity of humanizing our enemies as well as our allies In the past, we have humanized the enemy by converting him, one way or another When he becomes democratic or allows the women to vote or something like that, we let him in But since the Stone Age we have never faced the need of taking the enemy, *while he still is the enemy,* into the fold of mankind and treating him as we treat our brothers and our allies

'The future of mankind depends upon some such break through, some recognition that we have become the keepers of our enemies, not after we have conquered them or converted them but while they are our enemies This for the first time puts all of mankind operatively into one group, and for the first time makes it politically and socially necessary, as well as possible to realize the dream of the great religionists, who recognized that every man is a child of God"

Appendix:

Possible Research Projects

This appendix is a report prepared by Professor Douglas Heath of the Department of Psychology of Haverford College at the request of the Research Committee of the Academy, of which Dr Otto Klineberg is Chairman It is a list of hypotheses for research testing drawn from the stenographic reports of the Academy Symposia of 1957, 1958, and 1959 References relate to the stenographic reports and not to the printed volumes The list is presented in the belief that it may be of interest to scholars in the field of religion and health The stenographic reports are available to members of the Academy at the Academy offices in New York They may not be taken from the Academy Library

Key

H = *Hypothesis about some predicted relationships*
S = *Study proposed with no specific relationship indicated*
AI = *Arden House Conference 1957*
AII = *Arden House Conference 1958*
AIII = *Arden House Conference 1959*

Possible Research Projects

I SOME PHILOSOPHIC HISTORIC STUDIES

A Effect of new advances in thought on religious beliefs, and an analysis of the kinds of response religion has made to the challenges of new ideas, *AI 61 62*

1 The response of different religions to deterministic views of man, e g , psychoanalytic view, *AIII 46*

B Impact of religious thought on the behavioral sciences and the types of problems religion poses for behavioral sciences, *AI 62*

C What is common and what varies in the various religious approaches to mental health? *AI 302*

D Analysis of the historical changes in religion from being group oriented to being individual centered, *AIII 55*

1 What are the role changes of the minister as a consequence of increased behavioral science knowledge? *AIII 59*

2 Analysis of the relationship between industrialization and the increased interest in mental health and pastoral counseling, *AIII 45*

II DEFINITIONAL (DIMENSIONAL) ANALYSIS

A The following traits characterize the mature religious individual

1 Respect and reverence, *AI 129*

2 Concern about others and their welfare, *AII 176*

3 Religion is intrinsic (turns away from self) rather than extrinsic (self serving), *AII 99*

B The following traits characterize the mentally healthy adult

1. Appropriately balances between the individual and environment to be both creative and appropriately conservative, *AI:192.*

2. Is "becoming," "in creative tensioo," *AI:217;* is striving for emotional experience, *AIII:151;* is realizing or fulfilling self, *AI:192.*

3. Realistically accepts reality, *AI:154.*

4. Tolerates and integrates unavoidable frustrations into bis personality, *AIII:138.*

   a. Continues to "grapple" witb the world rather than withdraw from it in the face of frustration, *AIII:146.*

5. Not bouod by either the past or the present but can look forward to the future, *AIII:225.*

6. Is responsible, *AI:80, 213, 221.*

7. Loving orieotation toward others

   S: Study "love" and other positive qualities which are now largely ignored in psycbological researcb, *AI:76.*

8. Capable of enlarging his community belongingness, *AI:241.*

9. Religious orientation

   H: Religious orientation is not relevant to a person's mental health, *AI:91, AIII:22.*

   H: A man without *awareness* of any religious need can be content and mentally healthy, *AII:142.*

   H: Personal satisfaction and contentment require a free conscious relation to a God or some unified religious meaning in life, *AII:129, 132.*

   S: What are the characteristics of mature adults and what are their attitudes toward religious problems? *AI:153.*

III DEVELOPMENTAL DETERMINANTS OF RELIGIOUS BEHAVIOR AND EXPERIENCE

A Determinants of religious behavior and experience

1 Basic need for religious experience

S Determine the extent and manifestations of a need for some kind of religious experience across cul tural groups, *AII 249*

H Each individual has a need ' to have a relationship to the universe," has a "cosmic sense," *AIII 66*

S Survey the motives of individuals for joining a formal religious organization *AII 105, 106*

H Too great discrepancy between an individual s capacity and the culture's demand for relig ious experience will produce alienation, *AIII 66*

2 Infancy and childhood determinants

a Dependency needs their satisfaction and frustra tion

H Extrinsic self serving religious individuals are dependent and basically infantile, *AII 99*

H Early protective parental caring relation, de spite subsequent stress and parental loss, is a necessary condition for developing later posi tive religious beliefs, *AII 33*

H Ministerial students seek a "protective father ' in their religion because of deficient parental care in childhood, *AII 133* (e g , disruption in the father son relationship *AII 98*)

H Mature religious behavior requires the accept ance of one's own dependency needs, *AI 129*

H Severe unstable childhood experience may pro- duce subsequent religious punitive attitudes, *AII 32*

b. Trust and its effects

H: A sense of trust is a basic psychological condition for subsequent development of a faith, *AII:21, AIII:168.*

S: Study the religious beliefs and faith of children who have and have not had a basic trust experience, *AI:29.*

H: A basic trust in a father who later becomes inadequate to the child is a precondition for developing a subsequent all-perfect God-father image, *AII:29.*

H: Abandonment by or death of loved one, after a period of trust, produces a projection of trust into an ever-present "God," *AII:37.*

H: Displacement of trust from a loved one to a "higher power" results in diminution of trust in the original trusted person, *AII:36.*

c. Respect

H: Development of the capacity "for respect, for deference, fnr reverence" is essential for the subsequent develnpment of a religious attitude, *AIII:142.*

d. Adult attitudes toward infancy and childhood

H: Attitudes by adult toward the psyeholngical meaning nf childhood and adolescence may determine the type of religious behavinr he will show as an adult, *AII:90.*

S: Study the ambivalence between an adult's rejection of "childlike and childish" and "adnlescent" behavior and his acceptance of the religinus injunctinn tn "be like a child," *AII:80.*

H: The adnlescent surge fnr adult status may be a flight frnm the implications nf his own

negative attitude toward being a "child," *AII 90*

3 Social determinants of religious behavior and experience

H The type of religious behavior and experience manifested is determined by the type of social and cultural forms, *AIII 41*

H Type of religious practices followed, e g, visions, *AIII 76*, meditation, prayer, is a function of the existing cultural forms, *AIII 76, 140*

H Type of religious beliefs, e g, nature of God, is determined by the group's social experience or forms, *AIII 83*

H Increased urbanization and its socio psychological consequences is inversely related to the extent that religious beliefs affect the daily life of individuals, *AIII 68*

4 Situational crises

H The breakdown of a "fixed rigidity" of belief in time of crisis may produce new religious synthesis, *AII 92*

S Study the development and changes of religious behavior under conditions of personal and social crisis and the effects of such changes on subsequent behavior, *AII 252*

B Developmental forms of religious behavior and experience

1 Developmental trends

S Make a detailed descriptive study of the developmental forms of religious behavior from infancy to death, *AI 239*

H Religious development progresses from an extrinsic self serving to an intrinsic turning away from self direction and the rate of development

differs for different individuals and for different cultural groups, *AII:109.*

S: Study the conditions under which the transition from an extrinsic to an intrinsic type of religious experience occurs, *AII:111.*

S: Study the conditions under which the transition from an intrinsic to an extrinsic type of religious experience occurs, e.g., regressive religious development.

S: Make a study of the development of religious beliefs, superego or conscience, *AII:55, AI:171,* and ethical beliefs, *AII:236.* (c.f. Piaget.)

S: What are the stages in the "externalization of conscience"? *AI:171.*

H: Neurotic guilt is about the "bad" self while religious sin is guilt about one's act, *AI:206.*

S: What are the educational conditions that lead to healthy or neurotic guilt? *AI:206.*

S: A comparative cultural study of the different religious forms used to facilitate religious development of the child, adolescent, and adult and to assist in the solution of his developmental conflicts and problems, *AII:74, 253, 254.*

2. Childhood religious behavior and experience

H: The content of child religious fantasies is related to the kind of social and emotional experience he is undergoing, *AII:32.*

H: The content of the religious belief of a child is related to the type of childhood thought pattern characteristic of that age, *AII:71.*

S: What is the relation of Piaget's descriptive study of developmental forms of thought to the child's conception of reality and religious beliefs?

H Increase in the abstract and operational thought ability of the adolescent transfers a personalized concrete and immediate conception of God into an abstract and impersonal one, *AII 71*

H The quality and type of one's early interpersonal relationships determine one's conception of God, *AII 33*

3 Adolescent religious behavior and experience

H Adolescent's religion both reflects and controls his modes of handling conflict, *AII 72*

H Doubt about religious beliefs and God is a normal phase of adolescent development, *AII 97*

H Adolescent failure to doubt and maintenance of rigid belief in childhood faith results in no reintegration of religious beliefs and is an unfavorable indicator for subsequent mental health, *AII 97*

H Excessive or prominent religious doubt is an unfavorable indicator for subsequent mental health, *AII 97*

H Adolescent denial of a need for religion or for a religious orientation is related to subsequent mental stability, *AII 97*

S What are the personality characteristics of the antireligious personality? *II 261*

H Disbelief and doubt are defenses against religious guilt, *AII 118*

S What are the types of adaptive processes used by adolescents to solve religious doubt? *AII 98*

S What effect do adolescent conversion experiences have on later emotional stability? *AII 98*

S: What are the correlates of adolescent religious douht and turmoil? *AII:98.*

H: Religious confusion and asocial acting-out hehavior arc a consequeoce of parental failure to present adequate religious order or structure during development, *AII:124.*

H: Adolescent religious turmoil states are accompanied hy hcightened physiological activity, *AII:103.*

4. Adult aod mature religious behavior aod experieoce

H: Nature of early or cootemporary pareotal relatiooships is not ao important determinant in the developmeot of *mature* religious beliefs, *AII:98.*

H: Too great discrepancy between psychological and religious maturity produces cooflict and adjustive hehavior which in turn either rejects religion or isolates the implications of religioo from other areas of behavior, *AII:128, 129.*

5. Late adulthood

H: The onset of the involutional period provokes poteotial religious crises, *AII:156.*

H: Flight into activity to escape one's religious needs may produce involutiooal disturbaoce, *AII:137.*

H: Involutional period is characterized by cooflict between obtained level of achievement and earlier goal levels which provokes reevaluation of life's purpose, *AII:155, 156.*

H: Healthy resolution of childhood and adolescent problems provides the conditions for deepening one's religious life at the involutional period, *AII:169.*

H: The onset of old age provokes a potential religious crisis about the significance of death.

H Old age is marked by an increasing number of separations, e g , loss of friends, relatives, retirement, which magnify the importance of death, *AII 170*

H One's attitude toward the process of dying and toward death is determined by earlier developing religious experiences, personality structure of the individual (*AII 173, 179*) and cultural forms

IV DEVELOPMENTAL DETERMINANTS OF MENTAL HEALTH

A Childhood determinants (cf III, A, 2—Developmental determinants of religious behavior and experience In fancy and childhood determinants)

S What is the nature of affective development after the oedipal period? *AI 121*

S Study of the language development of the child as it reflects a developing sense of personal responsibility for his acts as seen in the growing differentiation between "me" and "I," *AII 40–44*

B Adolescent behavior and mental health

H There are differential rates of development of various phases of adolescent development both within an individual and within different cultural groups, *AII 74, 75*

S Determine the different cultural factors that either facilitate or hinder developmental maturity or the implementation of "progressive' methods of handling conflict, *AII 74*

S Study the process of "unorganization," "disorganization," and "organization" in the adolescent and their relation to the future creativity of the adolescent, *AII 89*

H Unorganized adolescents may be undergoing unconscious organization which may result in subsequent creative activity, *AII 89*

H: The "mature" adolescent does not accept adult social forms but out of his rejection of these social forms comes some creative synthesis, *AII:94.*

H: A developmental need of the adolescent is to gain status which may be accomplished by rebellion, *AII:93,* and subsequent identification with his peer group, *AII:101.*

H: Characteristic trait of adolescents is loneliness which may produce either feelings of inadequacy about forming new relationships or motives to move out of dependent relationships, *AII:93.*

H: Adolescents who use "progressive" methods for resolving conflicts endure stresses of later life better than adolescents who use other methods (regressive?), *AII:72.*

H: Characteristics of those "perennial adolescents" who use progressive methods are: zeal, spontaneity, idealism, *AII:79;* react strongly, whether positively or negatively, *AII:84;* continuously creative, ambitious, even if excessive, *AII:79,* rationalize instinctual impulses, *AII:77;* willing to take a chance, *AII:82;* creative rebel against society, *AII:94.*

H: Difference between a neurotic and a healthy adolescent is the capacity for reversibility of behavior symptoms, *AII:78.*

S: Study the differences between the "perennial" and the "nonperennial apathetic" adolescent, *AII:98.*

S: Find methods by which to encourage and use for adaptive purposes in adulthood the "youthful" characteristics of the "perennial adolescent," *AII:85.*

S: For all age levels, study the preferred types of familial and social organizations that promote future mental health, *AIII:184.*

S. What are the social and cultural forms that hinder developmental maturing? *AII 74*

C Situational determinants of mental health

H Environmental stimulation is a necessary condition for the maintenance and functioning of man's personality integration, *AIII 153*

V SOCIO-CULTURAL RELATIONSHIPS OF RELIGIOUS AND MENTALLY HEALTHY BEHAVIOR

A Of religious behavior

1 Some socio cultural characteristics

H All societies develop some beliefs about personal or familial continuity after death, *AIII 110*

H· Societal groups differ in their demand for type and amount of individual religious behavior and may vary in this demand over time, *AIII 137*.

S What are the cross-cultural types of practices for introducing the child to a group's religious beliefs, *AII 254*, and what is their relative effectiveness?

2 The effects of participation in a religious group

S What is the psycho-social effect of identification with a religious community?

H. Psychological "belongingness" to a religious community is a condition for maintaining mental health, *AI 231*

S What are the different religious groups' institutionalized and other methods by which to promote "belongingness" or identification with the group?

H Disintegration of a group's religious structure produces an increase in the incidence of emotional difficulties in the group, *AI 233*

3 Alienation from the religious group

H The more socially cohesive is the group, the less the sense of alienation persists among the members of the group, *AI 222*

H: The loss of a "sense of community" produces self-devaluation and rejection, *AI:22, 224.*

S: What are the determinants of self-hate in minority religious groups? *AI:235.*

S: What are the different methods different religious groups have of threatening alienation? Study the use of alienation threats as a means of maintaining group belongingness and group continuity, *AI:242.*

4. The relation of a religious group to other groups

S: What are the advantages and disadvantages to the individual of greater identification with a smaller or larger group?

S: To what extent does identification with a smaller religious group interfere or facilitate identification with a larger religious group? *AI:232.*

H: Successful identification with a larger group depends upon earlier identification experiences with smaller groups, *AI:241.*

S: What are the effects of religious group identification on intergroup relations? *AI:309.*

S: What are the conditions under which participation in an "in-group" prevents healthy relations with an "out-group"? What "in-group" characteristics define an "out-group"? *AI:249, 250.*

S: What are the relationships between prejudice and nonprejudice and religious believers and religious nonbelievers of the intrinsic and extrinsic type? *AII:119.*

H: Extrinsically religious individuals are significantly anti-Semitic, *AII:108* (dependent and infantile, *AII:99*).

H: Extrinsically religious children are

not prejudiced, but if they overidentify with an in-group they will become prejudiced, *AII 116*

H Intrinsically religious individuals are significantly nonprejudiced in comparison with extrinsically religious individuals, *AII 108*

B Of mentally healthy behavior

S What are the specific healthy and unhealthy features of different societies or religious groups?

H Authoritarian types of social and religious groups are resistant to new religious revelations or social change, *AI 188*

S Study the flexibility of different religious groups for assimilating new knowledge and change, *AIII 66*

H Individuals will achieve mental health more easily in certain types of groups than in other types, *AI 158*

S Study the problem of individual adaptation to a pathogenic society and the implications of the quality of his "adaptiveness" for his mental health, *AI 186*

S What are the therapeutic variables operating in "therapeutic groups," e g, Alcoholics Anonymous? *AI 247*

VI MENTAL HEALTH IMPLICATIONS OF RELIGIOUS PRACTICES AND BELIEFS

A Religious beliefs as motivating and organizing factors

H Individual's religious beliefs (intrinsic?) serve as an adaptive potential for responding to stress, *AI 258*, and resisting disorganization, *AII 70*

H Religion serves the social group as a source of integration, *AIII 21*, and provides social cohesion, *AII 41, AI 187*

H: Religious movements may be extremely socially disruptive and disintegrating, *AIII:41.*

S: What are the psychological and biological consequences of a "religious" life? *AI:146, 151.*

S: Study "ethically good" or highly religious individuals to determine their associated personality characteristics, *AI:117.*

H: A "good religious" individual shows more physical illnesses than a less conscientious, thoughtful individual, *AI:146.*

H: Other-centered individuals have fewer physiological complaints and illnesses than self-centered people, *AI:175.*

S: Study the quality of the religious life of biologically healthy and unhealthy individuals, *AI:150, 162.*

B. Mental health of *specific* religious forms and practices

1. Forms of belief and worship

S: Study the religious and ethical beliefs of different religious groups and their effects on the mental health of the individuals, *AII:252, AIII:124.*

S: Analyze the behavioral effects of different forms of worship in different religious groups, *AII:249, AIII:124.*

S: What personality types are congruent with what type of worship form? *AII:129.*

S: Study the variables that determine the effectiveness of various religious methods of restimulating religious faith, e.g., dancing, sacrifices, prayer meetings, etc., *AIII:140.*

H: Institutional attempts to seek "salvation-type" experiences are generally ineffective and tend to produce strain within an individual, *AIII:141.*

S: What are determinants of the amount of

mortification, celibacy, solitariness an individual is able to endure without loss of personality integration? *AIII 149*

H Amount of asceticism, e g, instinct renunciation, is directly related to occurrence of emotional symptoms of illness, *AI 203*

2 Confessional and sacrament of penance

H The psychological effects of the confessional are a product of an interaction between the level of religious and psychological maturity of the individual, *AIII 47, 48*

H Infantile or neurotic individuals will not be psychologically assisted by confession, *AIII 47.*

S Study the religious beliefs of those who are and those who aren't assisted by confession, *AIII 48*

H Acceptance of the sacrament of penance promotes continued emotional stability, *AII 168*

H Neurotic individuals resist being forgiven in the sacrament of penance, *AII 161*

S Determine the relation between attitude toward penance and subsequent mental health of the individual, *AII 162, 164*

3 Magic

S Explore religious "magical" practices and determine their effect on the religious individual, *AIII 69, 70*

H Ritualistic worship forms are compulsive magical procedures to allay anxiety, *AIII 111*

S Study the "therapeutic" variables involved in successful "magical" or faith cures, *AI 168, AIII 63*

S: Comparative study of magical practices io various American subcultural and religious groups, *AIII:112.*

4. Death and mourning rites

S: What are the determinants of attitudes toward death? *AI:67, AIII:108.*

H: Personal or social attitudes toward death are a functinn of the type of cause attributed to death, e.g., personal responsibility, accidental cause, someone else's responsibility, *AII:-212.*

H: Attitude toward death and the process of dying, *AII:190,* is determined by earlier religious experiences aod the type of personality structure of the individual, *AII:173.*

S: What are the personal and cultural attitudes toward any type of separatioo? *AII:243.*

H: Too great a belief in immortality is inversely related to the inability to tolerate separatioo and is a sign of immaturity, *AII:243.*

H: Personality growth is depeodent upon continuous separations, *AII:243.*

S: What are the different institutional and other methods available fnr preparing for death? *AI:67, AIII:108.*

S: Study the psychnlngical significance nf different grief and mnurning rites in different cultures, *AII:184.*

S: What mentally healthy psycholngical and religinns procedures are available fnr assisting a person tn accept dying, *AII:198,* or the death nf somenne else?

S: What are the psycbological consequences nf grief for the individual? *AII:254, 256.*

S: What are the best methods for helping a youngster comprehend death? *AII:239.*

VII. PSYCHOPATHOLOGY AND TREATMENT

A. Social and religious forms of psychopathology

H: The incidence of psychosis is not significantly different in primitive and nonprimitive groups, *AIII:73.*

H: The type of aberrant behavior patterns found in a society are shaped by the social, cultural, institutional forms (*AIII:64*) and religious beliefs of the society, *AIII:113.*

H: Despite divergences in form, the underlying mechanisms of emotional disorder are the same from one society to the next, *AIII:65.*

H: Socio-cultural factors determine the frequency and type of visions, *AIII:88.*

S: Are there any universal types of visions found in all societies? *AIII:87.*

S: Are there any differences between the type of vision experienced in primitive and more cultured groups? *AIII:75.*

S: What are the criteria used in different cultural and religious groups for differentiating between "significant" and "nonsignificant" religious visions? *AIII:89.*

H: The distinction between a schizophrenic hallucination and a mystical experience or vision is that the vision is integrated within a theological framework, *AIII:86, 87, AIII:100,* and is a preparation for subsequent behavior, *AIII:101, AI:177.*

S: Study the integrating effects of mystical states and visions and their consequences for attitudinal reorganization, *AI:74.*

B. Religious forms and beliefs as disorganizing factors

H: Religion fosters and reinforces infantile dependency and meets infantile magical needs, *AI:126, 127.*

H: Religious conflicts may produce mental illness, *AI:166.*

S: What are the conditions under which high goal level, ethical or religious, produces abnormal symptoms? *AI:163, 203.*

S: What are the effects on the individual of holding irrational, superstitious religious beliefs? *AII:252.*

S: What are the types of religious behavior which are pathogonomic and/or indicate that future abnormal behavior may occur? *AII:98.*

C. Religion and psychotherapy

1. Attitudinal factors

S: What is the relation of the community's religious attitudes toward mental health and illness and the type of treatment methods, e.g., open hospital, preferable for mentally ill? *AI:228, AIII:187.*

H: An individual's attitude toward illness is a product of an interaction of attitudes toward cause of illness, method of treatment, and who is responsible for the cure of the illness, *AIII:107.*

S: Differential characteristics of the patients who seek a religious rather than a psychiatric counselor.

S: How are religious and ethical biases and attitudes of the therapist nonverbally communicated to the patient and what effect might they have on the therapy process? *AI:299, 315.*

2. Analysis of therapy process

S: Translate and reinterpret psychotherapeutic processes into religious terms or vice versa, *AIII:27.*

S: Study the similarity and dissimilarity between psy-

chotherapy, educational, and parental goals for child development, *AI 79*

S Survey the type, extent, and effectiveness of religious counseling, *AI 312, 314*

3 Favorable therapeutic conditions

H The basic variable contributing to successful therapy is the "therapeutic personality" of the therapist or counselor, *AI 224, 226, AIII 56, 62*

H Similarity of religious, cultural and class status between patient and therapist facilitates the treatment process, *AIII 213*

H For certain personality types, some social distance (whether religious, class, etc) between the therapist and the patient is n preferred condition for treatment, *AIII 221*

4 Religious and mental health personnel

S How does a religious counselor differ from a psychological counselor nnd what are the advantages nnd disadvantages accruing to each role? *AI 320, AIII 50*

S Is the counseling role of the minister now undergoing change? *AI 268, AIII 27, 59*

S What are the religious, class and other characteristics of our mental health and religious workers? *AIII 33*

H Psychotherapists and pastoral counselors have the same social background, *AIII - 30*

S What are the determinants of a choice of the ministry as a profession? *AIII 33*

S What are the determinants of interpro fessional co operation and conflict between the psychologically and religiously trained specialist? *AIII 54*

S: What are the criteria for seleeting stable religious specialists and what role does a "visioo" or "call from God" play in the selection assessment? *AIII:78.*

S: How does ooe train both religious aod psyehological specialists (a) to be open to continuing knowledge, (b) to be sympathetie to behavioral science knowledge, and, (e) to develop a "humanistie" view of human beings? *AIII:227.*

S: Study the conflict role images and their eonsequeoces which a theological studeot faces io seminary, *AIII:228.*

S: What eooditions promote a healthy "master-disciple" educational relationship? *AIII:-142.*

Participants

GORDON W ALLPORT, PH D,
Department of Social Relations, Harvard University

THE REV GEORGE C ANDERSON,
Director, Academy of Religion and Mental Health

THE REV WILLIAM C BIER, S J , PH D,
Chairman, Department of Psychology, Fordham University

THE REV SAMUEL W BLIZZARD, PH D,
Professor of Christianity and Society, Princeton Theological Seminary

THE REV WILLIAM J DEVLIN, S J , M D,
Professor of Psychiatry, Loyola University (Chicago)

THE REV J FRANKLIN EWING, S J , PH D,
Professor of Anthropology, Fordham University

FRANK FREMONT-SMITH, M D,
Medical Director, Josiah Macy, Jr Foundation

THE REV VINCENT V HERR, S J , PH D,
Chairman, Department of Psychology, Loyola University

THE REV HANS HOFMANN, PH D,
Director, Harvard University Project on Religion and Mental Health

RABBI I FRED HOLLANDER,
Director, Institute of Pastoral Psychiatry, New York Board of Rabbis

EDWARD J HUMPHREYS, M D,
Director, Pennsylvania Center for Alcoholism and Drug Addiction, Division of Behavioral Problems, Pennsylvania Department of Health

SAMUEL Z. KLAUSNER, ED.D.,
Director of Program of Research in Religion and Psychiatry at the Bureau of Applied Social Research, Columbia University

OTTO KLINEBERG, M.D., PH.D.,
Professor of Psychology, Columbia University

WILLIAM L. KOLB, PH.D.,
Fred B. Hill Professor of Sociology, and Chairman, Department of Sociology and Anthropology, Carleton College

THE REV. NOËL MAILLOUX, O.P., PH.D.,
Département de Psychologie, Université de Montréal, Président, Centre de Recherches en Relations Humoines

MARGARET MEAD, PH.D.,
Associate Curator of Ethnology, American Museum of Natural History, and Adjunct Professor of Anthropology, Columbia University

THE REV. HARRY C. MESERVE, D.D.,[1]
Rockefeller Brothers Fund

FOWLER MCCORMICK,
Former Chairman, International Harvester Company

THE REV. WAYNE E. OATES, TH.D.,
Professor, Psychology of Religion, The Southern Baptist Theological Seminary

TALCOTT PARSONS, PH.D.,
Department of Social Relations, Harvard University

THE REV. OTIS R. RICE, D.D.,
Former Executive Director, Department of Pastoral Services, The National Council of Churches of Christ in the U.S.A.

THE REV. D. H. SALMAN, O.P., PH.D.,
Département de Psychologie, Université de Montréal

[1] Since February, 1960, Director of Program, Academy of Religion and Mental Health.

DAVID L. SILLS, PH D,
Acting Director, Bureau of Applied Social Research, Columbia University

HARVEY J. TOMPKINS, M D,
Director, Reiss Mental Health Pavilion, St Vincent's Hospital, and President, Academy of Religion and Mental Health

GOODWIN WATSON, PH D,
Professor of Education, Teachers College, Columbia University

HAROLD G WOLFF, M D,
Professor of Neurology and Psychiatry, Cornell University Medical College

ERWIN S WOLFSON,
Chairman, Board of Directors, Diesel Construction Company